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EXPLORING WOMEN'S EXPERIENCES OF MENOPAUSE

Section A: What are the emotional, psychological and relational experiences of women who experience menopause early? A meta-synthesis.

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Summary of the MRP

Section A

This review aimed to understand the psychological, emotional and relational experiences of women who experienced menopause early. A systematic literature search was undertaken, and 14 relevant studies were found. These studies were critically appraised and thematically synthesised. The findings highlighted that women experienced changes in self-concept, feelings of loss, shame and isolation, an altered sense of belonging and changes in their relationships. The review limitations, clinical implications and areas for future research are outlined.

Section B

This qualitative study explored UK Black women's experiences of their menopause transition, their perspectives on the role of ethnicity in their experiences and what they found helpful or unhelpful for navigating this lifestage. Ten women who were postmenopause were interviewed, and their transcripts were interpreted using Reflexive Thematic Analysis. Findings highlighted that women had little prior knowledge about menopause and varied in the somatic changes they experienced and their emotional and cognitive responses. Various strategies were used to support their adjustment. Information seeking and support from others was deemed helpful, and perspectives on the role of ethnicity varied. Findings are discussed in relation to existing literature. Limitations, clinical and research implications and future directions are outlined.

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Major Research Project

Section A: Literature Review

What are the emotional, psychological and relational experiences of women who experience menopause early?

Word count: 7926

Abstract

Background and Aims

Quantitative evidence suggests that women who experience menopause early may be at risk of impaired psychological wellbeing. Health guidelines often reference the importance of psychosocial support for these women but give little specificity as to what this support may need to address. The available qualitative research into these women's experiences has not been synthesised, which may clarify their psychosocial needs. Therefore, a meta-synthesis of qualitative research that explored the emotional, psychological, and relational experiences of women who experienced menopause early was conducted.

Method

A systematic search of Medline, PsycInfo, CINAHL, and ASSIA databases was undertaken. Fourteen studies were critically appraised and analysed using thematic synthesis.

Results

Six themes were identified: A psychological shift in self-perception; loss of an imagined future; isolation and wanting to belong; protecting the self through secrecy; relationships shape and are shaped by menopause; and adjustment and moving forward.

Conclusion

Women who experience menopause early may undergo changes in self-concept, feelings of shame, isolation and loss, and changes in their relationships. Psychosocial support to address these areas may be helpful. Further research on women's experiences and adjustment processes may be beneficial.

Keywords: Early menopause, Premature menopause, Iatrogenic menopause, qualitative, lived experience

Introduction

Synthesis overview

This review introduces early and premature menopause and its link to compromised psychological wellbeing through quantitative research and theoretical perspectives.
It notes recommendations that women access psychosocial support but highlights the lack of specificity on what this support should address, potentially due to the limited syntheses of women's experiences of this phenomenon. Recent syntheses and rationale for an additional review are outlined. The meta-synthesis process and critical appraisal of the literature are presented, followed by the findings and implications.

Early and premature menopause

Menopause is a singular point in a woman's reproductive life stage marked by the cessation of menstruation (NHS, 2022). Vasomotor symptoms (VMS), i.e. hot flushes and night sweats, are the main physiological changes associated with the menopause transition (MT). However, other somatic and psychological changes, including sleep disturbances, musculoskeletal pain, impaired concentration and low mood, may be experienced (NHS, 2022). At its simplest, the MT can be viewed as simply a biological event. However, it is also considered a biopsychosocial process as women's experiences are influenced by multiple factors, e.g., physiology, cultural context, and personal attitudes (Hunter, 2019).

There is variability as to when women reach menopause, with spontaneous onset from age 45 considered typical or natural (NHS, 2022). However, approximately 12.2% of women experience *premature menopause* (PM) before age 40, and 3.7% undergo *early menopause* (EM) between the ages of 40-44 (Golezar et al., 2019). EM and PM can arise spontaneously or following a medical intervention (Golezar et al., 2019). There are various terms for

menopause that occurs before age 40 and debate regarding the most accurate terminology, particularly due to the potential for intermittent ovarian activity that can result in pregnancy, unlike with EM or typical menopause (Panay et al., 2020). A discussion of these terms and debate is beyond the scope of this review; however, the term 'premature menopause' is used within this review as it is used in common parlance and within research and health literature (e.g. Faubion et al., 2015; NHS Inform, 2023). Definitions for terminology used within the review can be found in Table 1.

Table 1

List of definitions

Term	Definition
Menopause	A singular event reached when a woman has her final menstrual period. It is confirmed after 12 months of no menstruation (NHS, 2015). However, this term is often used in common parlance to refer to the menopause transition, e.g. 'going through the menopause.' Women who experience menopause spontaneously from age 45 are referred to as having had a typical or natural menopause (NM).
Premenopause	The entire reproductive stage of a woman's life before her final menstrual period (NICE, 2015).
Perimenopause	The stage before the final menstrual period when a woman may experience signs associated with approaching menopause (NHS, 2015).
Postmenopause	The years after a woman's final menstrual period (NHS, 2015). Within this review, postmenopause also describes the stage after a woman has experienced iatrogenic menopause.

Spontaneous menopause	A loss of ovarian activity due to unknown causes (idiopathic) or not induced by a medical intervention (Shuster et al.,2010). Spontaneous causes of early and premature menopause include genetics, autoimmune disorders, metabolic syndromes or a consequence of infectious or inflammatory conditions (Shuster et al., 2010).
Iatrogenic menopause	A loss of ovarian activity due to surgical procedures such as a bilateral salpingo-oophorectomy, or BSO (the removal of the ovaries and fallopian tubes), total hysterectomy (a BSO with the removal of the uterus and cervix) or cancer treatments such as radiotherapy and chemotherapy (Shuster et al., 2010).
Early menopause(EM)	A recognised term that refers to menopause that occurs between the ages of 40-44 from either spontaneous or iatrogenic causes (Shuster et al., 2010).
Premature menopause (PM)	A recognised term to describe the loss of ovarian activity before age 40 for spontaneous or iatrogenic causes (NHS, 2015). Other recognised terms are premature ovarian insufficiency (POI) and premature ovarian failure or POF (Panay et al., 2020).
Women who have experienced menopause early (WEME)	A collective term used within this review to refer to women who underwent spontaneous or iatrogenic menopause before age 45 (i.e., premature and early menopause) and women who experienced iatrogenic menopause after the age of 45 but were still menstruating at the time of their medical intervention. Within this context, their menopause could be considered 'early' as it was induced and thus occurred before the onset of natural menopause.

Despite the vast body of research on the pathophysiology of EM and PM, research on its psychosocial implications is more limited (Groff et al., 2005). However, available research suggests that it can cause emotional and psychosocial challenges for some women (Li et al.,

2019). Theoretical perspectives that may offer some explanation as to why are discussed below, followed by an overview of relevant quantitative research.

Theoretical perspectives

The experience of EM/PM can be viewed from multiple perspectives with relevant theoretical perspectives relating to infertility, cultural expectations of women, and stigma.

While infertility is only one physiological consequence of EM/PM, its psychological consequences have received theoretical attention, with perspectives drawn from non-fertility-related areas being adapted to understand this experience (Covington & Burns, 2009). For instance, adult development theories, such as those by Erikson (1980**)** and Havighurst (1972), cite having children as a fundamental adulthood task, which may explain why infertility evokes feelings of grief and loss in some women. Infertility has been associated with multiple losses, including life goals and a sense of purpose (Covington & Burns, 2009). Consequently, theoretical frameworks like Kubler Ross's (1969**)** stages of grief (denial, anger, bargaining, depression, and acceptance) are used to understand women's emotional responses to infertility (Covington & Burns, 2009).

A common critique of these developmental theories is that they are based on male assumptions and may place too much emphasis on women's reproductive capacity (Greene, 2015). However, the expectation of motherhood also exists within sociocultural ideas of a typical woman's lifespan; therefore, for some women, not becoming a mother may require a psychological adjustment (Greene, 2015). Thus, the psychological disruption experienced by some women experiencing EM/PM may arise not only from the inability to have a child or more children but also due to diverging from these sociocultural expectations.

Relatedly, some theories suggest that failing to meet our own expectations or the expectations of others can lead to emotional disruption. Self-discrepancy theory (Higgins, 1987) posits that emotions such as disappointment, guilt or sadness can arise from perceived discrepancies between our actual self, our ideal self, and our 'ought' to be self (both from our perspectives and others). In the context of EM/PM, differences between a woman's reality and her ideal or expected role (i.e. mother or fertile partner) may lead to difficult emotions depending on the salience of these discrepancies for the individual.

Stigma can also influence one's adjustment to health events (Singer, 2019). There are different definitions of stigma, with common elements being a perceived difference and loss in status (Link & Phelan, 2001). Women who have experienced PM have reported feeling stigmatised, or their accounts have been associated with stigma (e.g. Singer, 2019; Davis et al., 2010). This can stem from negative sociocultural connotations of ageing (Singer, 2019), infertility (Davis et al., 2010) or health conditions such as cancer that can lead to iatrogenic menopause (Knapp et al., 2014). Although there is an absence of specific theories on EM/PM and stigma, some theories posit that perceived stigma can adversely affect an individual's psychological wellbeing (e.g. Quinn and Chaudoir, 2009; Corrigan, 2004).

These theoretical perspectives suggest that EM/PM can have a considerable psychological impact on women. As such, quantitative research has investigated these women's emotional and psychological wellbeing, with most research investigating PM populations.

Quantitative research on PM and wellbeing

A recent meta-analysis of health-related quality of life (HrQoL) studies with women with PM, where HrQoL included facets such as affect, perceived social support and engagement, and self-esteem, found lower levels of reported mental health and social functioning compared to women with typical ovarian function, albeit with small effect sizes (Li et al., 2019). Cross-sectional studies using various measures of psychological health found that women with PM have impaired psychological wellbeing compared to women of typical menopause age (e.g., Liao et al., 2000; Mann et al., 2012; Deeks et al., 2011).

Despite using different outcome measures and methodologies, these findings suggest that psychological wellbeing may be impaired in women with PM compared to the general population (ESHRE, 2016). However, whether these observations are generally associated with living with a long-term condition or specific to PM needs further investigation (ESHRE, 2016).

One consideration regarding the existing body of research is the identification and definition of women who experience menopause early. For both EM and PM, the definition is one of age -with EM being menopause reached before 45, and PM before 40. Although these diagnostic criteria have utility from a biomedical perspective, the use of age could be considered arbitrary when identifying women who have experienced menopause ‘early’ and who may experience psychological consequences from this. Another group of women who could also be considered to have experienced their menopause ‘early’ are those who experienced iatrogenic menopause over age 45 but during their pre-perimenopausal years, as their loss of ovarian functioning was induced before the onset of their natural menopause. For example, women who experienced iatrogenic menopause both before and after age 45 have

been researched together within the same study in the context of ‘premature menopause’ (Pasquali, 1999). The significance of this will be returned to; however, the psychosocial needs of women who have experienced PM will be addressed below, as most of the literature focuses on this population.

Addressing the psychosocial needs of women experiencing PM

Due to the potentially complex physical and psychological needs of women with PM, a multifaceted healthcare approach is essential (Daisy Network, n.d.). Currently, there are no recommended models of care for PM management despite their recognised importance for improving clinical outcomes and ensuring evidence is translated into clinical practice (Jones et al., 2020). However, key review papers on PM management highlight the importance of psychological support. Specifically, Goswami and Conway (2005) proposed that women be offered psychological support to address the effects of PM on their health and relationships. This was supported by a recent white paper on PM management that stated women “should have easy access to specialist counsellors who can address their needs...” (Panay et al., 2020, p. 11). NICE guidelines state that women may require access to experienced healthcare professionals who can support them in managing the psychosocial factors associated with PM (NICE, 2019). However, what these psychosocial factors may be are not explicitly stated.

Although various interventions deriving from different theoretical orientations may be appropriate for addressing these needs, literature searching revealed that cognitive behavioural therapy (CBT) was the modality with an emerging evidence basis specific to EM and PM populations. CBT appeared to lead to improvements in facets of emotional and social wellbeing in surgical menopause populations (Madhavan et al., 2022), and sexuality and the perceived burden of vasomotor symptoms in chemotherapy-induced menopause (Duijts et al.,

2012). However, in the latter study, no significant difference in women's reported mood or body image was found post-intervention (Duijts et al., 2012). A more comprehensive understanding of the perceived psychological and emotional impact of experiencing menopause early may inform how to develop future interventions. Compared to quantitative studies, qualitative research aims to provide rich, detailed descriptions of people's lived experiences (Barker et al., 2016). Thus, synthesising the available qualitative research on these women's experiences may elucidate these needs, inform clinical practice and highlight research gaps.

Hoga et al. (2015) meta-synthesised qualitative research on women's experience of natural menopause (NM) to inform the implementation of evidence-based practice; however, research on women with iatrogenic and premature menopause was excluded. A recent systematic review by McDonald et al. (2022) aimed to fill this gap by synthesising quantitative, qualitative, mixed-method, and grey literature on HrQoL in women with premature ovarian insufficiency, another term for PM. Three themes were developed related to the challenge of receiving a diagnosis, isolation and stigma, and the perceived impact on identity due to impaired sexual functioning, body image effects and infertility. However, the focus on HrQoL limited the inclusion of qualitative data that could provide other insightful data on women's lived experiences. Additionally, this synthesis only included studies from PM populations, excluding studies that might hold relevant information on the experiences of a broader population of women who have experienced menopause early, specifically women with EM and iatrogenic menopause over age 45. Therefore, there is a need for a meta-synthesis of qualitative research into the experiences of these women.

Rationale and aim for the review

To the author's knowledge, there had not been a synthesis of qualitative research regarding the psychosocial experiences of women who experience menopause early. Therefore, this review critically appraised and synthesised the available qualitative literature to answer the question: What are the emotional, psychological, and relational experiences of women who experience menopause early? A broad review question was chosen to expand the breadth of the findings which could offer insights into the development of more tailored interventions, and aid the identification of potential areas for further research. Additionally, it would maximise the relevance and applicability of the findings across the diverse healthcare disciplines that provide therapeutic and medical interventions to these women, including clinical psychology.

In an endeavour to be inclusive and also due to the limited qualitative research on experiences of PM, a decision was made to synthesise qualitative research with women who experienced spontaneous and iatrogenic menopause before the typical age of menopause onset of 45 (EM and PM populations) and women over 45 who experienced iatrogenic menopause as their loss of ovarian functioning was induced before the onset of their natural menopause and thus could be considered early. As outlined in Table 1, these populations are collectively called 'women who experienced menopause early' (WEME) within this review.

Method

Review design

The meta-synthesis method used for this review was thematic synthesis, as detailed by Thomas and Harden (2008) and informed by Thematic Analysis, a technique for developing and interpreting themes across datasets (Braun & Clarke, 2022). This approach was adopted

as it was designed to answer questions regarding people's experiences and specified clear process steps outlined below.

1. Initial phase: i) literature search, ii) screening the papers and quality assessment, and iii) data extraction
2. Thematic synthesis: iv) initial coding, v) generating descriptive themes, vi) developing analytic themes.

Search strategy

The search strategy employed the SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, Research type), which is used to identify key concepts when searching for qualitative and mixed-method research (Cooke et al., 2012). Two factors were identified for the search strategy.

1. Phenomenon of Interest: Menopause which occurs early (early, premature and iatrogenic menopause)

2. Design: Qualitative studies

CINAHL, PubMed, PsycINFO and ASSIA databases were chosen to source studies from psychological, social sciences, nursing and medical fields. Searches were conducted between 3rd and 5th December 2022. The search was pre-planned, and terms were informed by literature in the area (e.g., Panay et al., 2020). Databases were searched from their inception to the search date.

Search terms are outlined in Table 2. To ensure that literature on early, premature and iatrogenic menopause would be retrieved, search strings were devised on the phenomenon of interest (String 1 and 2), with String 3 relating to design. Within each database, two separate searches were conducted: Strings 1 and 3 combined using Boolean operator 'AND' and Strings 2 'AND' 3. The words 'emotional', 'psychological' or 'relational' were not used as search terms to avoid limiting the studies identified if these were absent from titles or abstracts. Instead, studies were first selected based on the criteria above and then screened for their relevance to the review question.

Table 2

Search terms used in the systematic search

String number	SPIDER topic	Specific terms used
String 1	Phenomenon	"early menopause" OR "premature menopause" OR "primary ovarian failure" OR "primary ovarian insufficiency" OR "premature ovarian failure" OR "premature ovarian insufficiency" OR "surgical menopause" OR "induced menopause" OR "diminished ovarian reserve" OR "poor ovarian response" OR "idiopathic menopause" OR "iatrogenic menopause"
String 2	Phenomenon	(menopause or climacteric) **AND** (surgery OR surgic*OR hysterectomy OR chemotherapy OR Oophorectomy OR Salpingectomy)
String 3	Design	"Qualitative" OR "mixed-method" OR "narrative" OR "grounded theory" OR "interpretative" OR "thematic" OR "phenomenolog*" OR "focus group*" OR "discourse*" OR "ethnograph*" OR "interview*" OR "lived experience*" OR "subjective experience*" OR "IPA"

Inclusion and exclusion criteria

This review identified qualitative and mixed-method studies that explored women's psychological, emotional and relational experiences of menopause that occurred early. Inclusion and exclusion criteria are outlined in Table 3.

Table 3

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
a)A qualitative or mixed methodology was utilised.	a)Not peer-reviewed
b) The women's first-hand perspectives were explored.	(b) Not written in English
c) The findings explicitly relate to women's psychological, emotional and relational experiences of menopause.	(c) The data solely related to treatment decision-making, symptomology description or management, the impact of interventions, or the experience of receiving a diagnosis of EM/PM.
d) The study identified the women as having experienced 'early' or 'premature' menopause.*	
e) The study identified the women as having experienced menopause following a medical intervention.*	
f) The study states that women were pre/perimenopausal before the medical intervention, or if not explicitly stated, it was clear from the inclusion criterion that the women were pre or perimenopausal, e.g. experiencing menstruation.*	

Mixed method studies were included if qualitative data could be extracted. Given the different populations within the group WEME, studies had to meet at least one of the starred criteria to maintain the validity of the phenomenon being explored. As the synthesis aimed to find patterns of experience across these studies, exclusion criterion (c) was adopted as there would likely be fundamental differences between the different

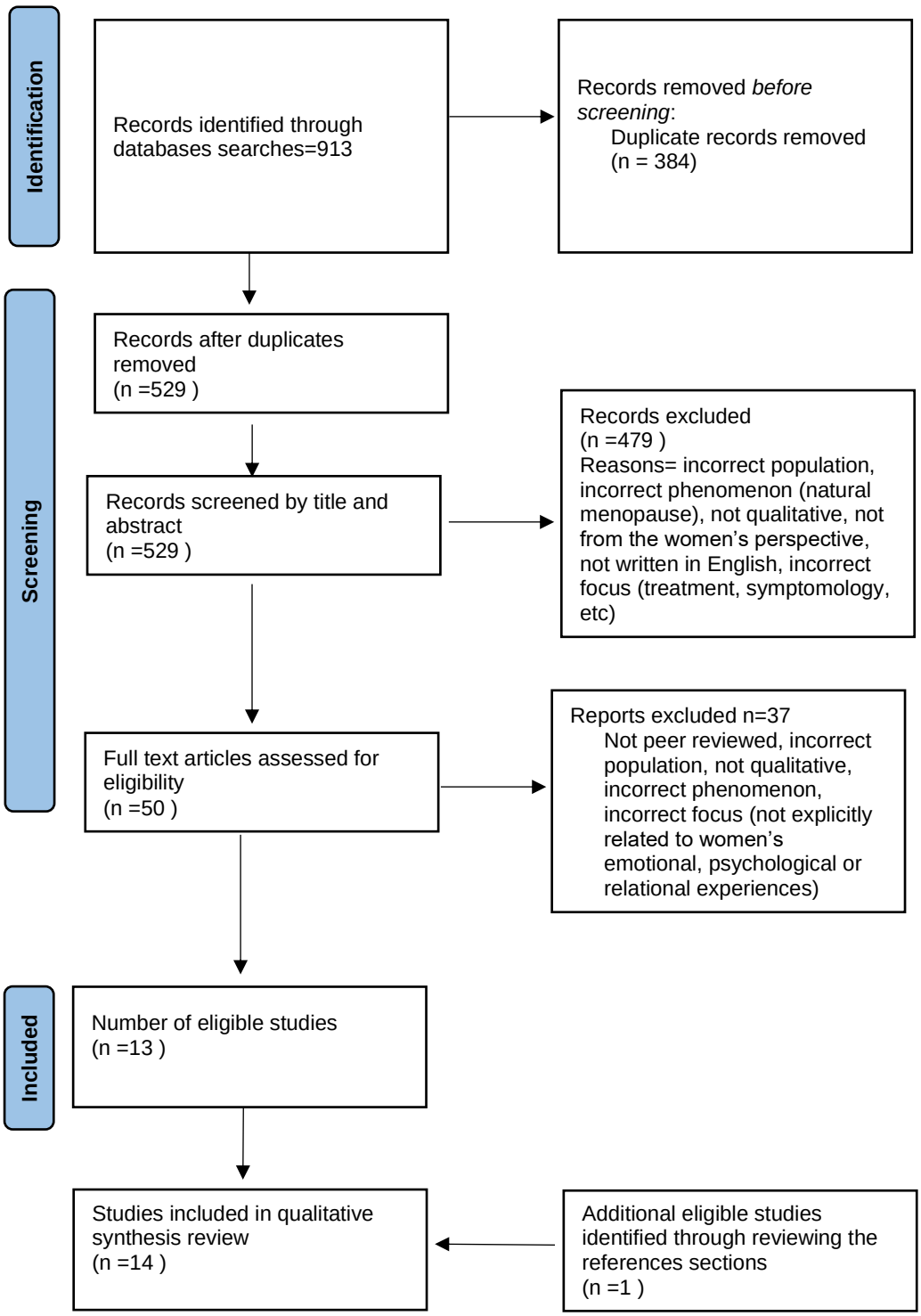
populations' experiences in these areas, and these studies would focus specifically on these areas.

Screening

The screening process is outlined in Figure 1. Duplicate articles were removed, and titles and abstracts were screened and excluded according to the specified criteria. A full-text review was conducted, and further papers were excluded. The reference sections of retrieved papers were also screened.

Figure 1

PRISMA diagram



Quality appraisal

The Critical Appraisal Skills Programme (CASP; n.d.) was used to critically appraise the articles by evaluating aspects including clarity of the research aims, design suitability, analysis quality, reflexivity, ethical considerations, and usefulness (Appendix A). Despite its limitations, such as its set responses potentially reducing the nuance within the overall evaluation, the CASP was chosen as it is an established tool suitable for novice researchers (Long et al., 2020). All reviewing was conducted by the author, with studies judged to be of a suitable standard if ≥ 7 items were present. For partial responses, a half point was assigned.

There is debate regarding the purpose of quality appraisals in meta-synthesis and variation regarding how they inform the final synthesis (Caroll et al., 2012). As no study was judged to have methodological flaws sufficient enough to warrant exclusion, all studies were included in the synthesis. Once completed, attention was paid to the balance of studies that contributed to each subtheme, specifically the study's data collection method and depth of analysis, to provide context to the findings.

Thematic synthesis process

Following guidance from Thomas and Harden (2008), data from the results sections were extracted for coding. Data were inputted into Nvivo 12 to assist the analysis process. Each line was read, and relevant data were coded for meaning and content (Appendix B). Data solely about physiological changes without indicating the perceived psychological or relational impact were not coded. For studies including women with iatrogenic menopause, only data deemed to refer to women's experience of menopause, as opposed to their primary health condition, were coded. The coding process allowed for 'translation', or the recognition of similar concepts across studies (Thomas & Harden, 2008). After review, the final codes

were organised by meaning into 17 descriptive themes and then further interpreted to create six analytical themes. The level of abstraction ('going beyond the data') required during the synthesis process has been debated (Thorne et al., 2004). Whilst some meta-syntheses require higher levels of abstraction, this may not be necessary when the original studies are directly concerned with the review question (Thomas & Harden, 2008). For this review, as primary studies directly addressed the review question, a sufficient level of abstraction was used to answer these appropriately. All coding and theme development was conducted by the author, and descriptive and analytical themes, along with their corresponding data were reviewed in supervision for quality assurance. During the analysis, supervisors supported the author in elucidating their emerging interpretations through discussions, suggested when further synthesis was required, and evaluated emerging themes' relevance to the review question.

Results

A total of 913 articles were identified, of which 13 met the inclusion criteria (see Figure 1). One paper was identified from reviewing the references section, resulting in 14 articles. Each study's key characteristics and findings are outlined in Table 4.

Table 4

Key characteristics and findings of the included studies

Study no.	Author (year)	Study location	Research topic and aims	Participants demographics	Menopause type	Cause of iatrogenic menopause	Data collection and analysis method	Summary of key findings extracted for the review
1	Abadi et al. (2018)	Iran	To explore how surgical menopause affected the sexual and marital relationships of Iranian women and how Iranian/Eastern cultural views impacted their experiences.	22 Iranian Muslim women. Aged 39-60 Ages 30-47 at the time of surgical intervention.	Iatrogenic	Hysterectomy due to benign conditions	Interview Qualitative content analysis	Women perceived a reduction in sexual and emotional intimacy with their partners. A loss of womanhood, youthfulness and their sexual identities was experienced. Menopausal symptoms affected their body image, and they kept their menopause secret from others due to shame and embarrassment.
2	Archibald et al.(2006)	Canada	To better understand the experience of sexual changes associated with chemotherapy-induced menopause and explore the emotional impact of negative changes.	30 women 31-57 (Mean age=45) Age at time of intervention not specified	Iatrogenic	Chemotherapy	Interview Thematic analysis	Worry and uncertainty regarding how long sexual changes would last and impact their relationships were common, as were feelings of frustration and anger. Women felt prematurely old and a loss of femininity. Some women felt indifferent about the sexual changes they experienced.
3	Boughton (2002)	Australia	To explore the experience of menopause in women who reached menopause before the age of 40. To examine	35 women Ages not provided EM/POI reached between 20-39	Mixed	Surgical intervention and radiotherapy	Interviews Hermeneutic phenomenology	Women experienced their bodies as ‘different’ and ‘problematic’, which resulted in self-body disruption and confusion. Women felt they did not fit the societal image of a menopausal

			women's descriptions of premature menopause, the meaning of this experience and how women responded to their experience.					woman and did not belong with 'younger' or 'older' women. There was grief and loss over their 'fertile self' and their feminine identity.
4	Davis, Zinkland and Fitch (2000)	Canada	To document the experiences and difficulties associated with treatment-induced menopause	8 women 33-57 Age at intervention not provided (Between 6 months-6 years post-treatment)	Iatrogenic	Chemotherapy, radiotherapy and hysterectomy	Interviews Collaizzi method (Descriptive phenomenology)	Women felt a sense of loss regarding their fertility, future plans and life choices. Women felt out of sync with their same-age peers. The experience of menopause was not a significant threat to most women's sense of womanhood. Reduction in experiences of sexual pleasure had consequences for romantic relationships.
5.	Golezar et al. (2020)	Iran	To explore factors affecting the quality of life of women with premature ovarian insufficiency within an Iranian cultural context	16 women 28-47 (Mean age=37) Age <40 at time of menopause	Spontaneous	-	Interviews Qualitative content analysis	Women had a range of negative emotional responses, including shock, grief, anxiety and hopelessness. Women's sense of femininity was threatened. Women reported feeling old and stigmatised, with a desire to conceal their loss of fertility.
6.	Halliday and Boughton (2009)	Australia	To establish which aspects of being a younger menopausal woman proved problematic and if the cause of premature menopause altered the experience.	98 women All participants under 40 (Mean age= 35)	Mixed	Surgical menopause and chemotherapy	Internet forum messages Thematic analysis	The emotional impact included loss, grief, shock and an altered sense of identity. Women can feel less feminine and attractive. Women feel different to peers and struggle with loneliness and isolation as others cannot share their experiences.

7.	Johnston-Ataata et al. (2020)	Australia	To explore how women's personal relationships shape their experience of early menopause and the development of their EM/POI identities.	25 women 28-51 25-44 at time of EM/POI diagnosis	Mixed	Treatment for cancer and benign conditions	Interviews Thematic narrative analysis	Three narratives were constructed which expressed variation in how EM/POI disrupted women's lives and their relationships. The quality of women's relationships and the extent of women and their networks (family and partner's) attachment to gender norms influenced women's adjustment.
8.	Knobf (2002)	USA	To examine the psychological and social problems for women with treatment-induced menopause and the psychosocial processes used to resolve these problems.	27 women Mean age=40.8 years Age at time of intervention not specified. 1-9 years since cancer diagnosis.	Iatrogenic	Chemotherapy	Interviews Grounded theory	Women felt unprepared for menopausal symptoms, and discussions about menopause were limited among peers. Women felt too young to be experiencing menopause and felt 'old'. Menopause symptoms were accepted and tolerated.
9.	Orshan et al. (2001)	USA	To describe the lived experience of women diagnosed with premature ovarian failure.	Six women 25-41 (Mean age=36) Aged <35 at time of menopause	Spontaneous	-	Interviews Collaizzi method (Descriptive phenomenology)	Women experienced loss and grief over loss of fertility and perceived loss of womanhood and purpose. There was fear about sharing being in menopause with others due to the potential reactions.
10.	Parton, Ussher and Perz (2017)	Australia	To examine how women constructed their gendered identities following cancer-induced premature menopause.	Survey sample: 695 women Interview sample: 61 women Mean age at interview=33	Iatrogenic	Treatment for cancer (unspecified)	Surveys and interviews Thematic decomposition (Discourse analysis)	Women felt they were incomplete women due to loss of fertility. Women felt a loss of choice and control over their lives due to altered fertility. Body image and sexual identity were negatively affected due to menopausal physical changes. There was anxiety and embarrassment about

				Average of 6.34 years since diagnosis				menopausal symptoms. Women felt different to both older and younger women.
11.	Pasquali (1999)	USA	To explore the lived experience of surgically or chemically induced premature menopause on women's sense of self.	11 women Aged 32-50 Mean age of menopausal onset was 45.	Iatrogenic	Chemotherapy/ hysterectomy for cancer or benign conditions.	Interviews Domain analysis	Changes in identity were experienced, along with a loss of womanhood and femininity due to perceiving their body as ageing. Some women experienced menopause as a purely physiological issue. Relationships and a sense of belonging were both positively and negatively affected. Women often felt out of sync with same-age peers and had difficulties relating to them.
12.	Pearce et al. (2014)	England	To explore the lived experiences of body image change following surgical menopause.	7 women 36-54. Age at intervention not provided. 6-19 years post operation	Iatrogenic	Hysterectomy due to cancer or benign conditions	Online text-based instant messaging interviews Interpretative Phenomenological analysis	The impact of menopause varied depending on the severity of menopause changes and the perceived impact on body image. Menopause had different meanings, including freedom from birth control and menstruation. Menopausal symptoms negatively affect body image and cause embarrassment. Sadness over their impaired fertility was experienced.
13.	Singer and Hunter (1999)	England	To understand what accounts women utilise when talking about early menopause and how they maintain their identity within the context of negative discourses.	13 women 23-40 (Mean age=31). 16-40 at diagnosis	Spontaneous	-	Interviews Thematic discourse analysis	Women experienced multiple losses, including a perceived loss of youth, choice and womanhood. There were changes in their sexual identity and negative repercussions on self-esteem and body image. Women felt isolated and

								different from their peers. Some hid their menopause due to shame and anxiety.
14.	Singer (2012)	England	To investigate women's experience of diagnosis of premature menopause, including perception of cause, treatment received, main concerns, and impact on psychological wellbeing	Number of qualitative responses not stated; 136 questionnaire respondents 19-61 at time of study Average age at diagnosis 31	Mixed	Reasons for iatrogenic menopause not provided	Questionnaire with quantitative and qualitative data Thematic analysis	Women had to adjust to many losses, including youthfulness, sexual identity and plans of motherhood. Several felt their femininity was threatened and that they were prematurely ageing. Low mood and anxiety were experienced. Supportive relationships were important. Some felt conflicted about whether to tell others about PM.

Characteristics of included studies

The studies were conducted between 1999 and 2020 in North America, Canada, Australia, United Kingdom, and Iran. The disciplines represented were clinical health (n=10), psychology (n=3) and sociology (n=1). A total of 495 women participated; however, Singer (2012) did not specify how many participants provided qualitative responses in their mixed method study, leaving 359 known participants within this review.

Details provided on participants' age at the time of the study and menopause onset varied, making it challenging to describe the total participant pool. From the available information, participants' ages ranged from 25 to 61 years. For age at menopause onset, six studies had participants aged ≤ 40 (PM); one study included participants ≤ 45 (EM); two studies included women with iatrogenic menopause >45 and five studies did not specify. Different menopause populations were represented: spontaneous menopause (n=3), iatrogenic menopause (n=7), and a mixed sample (n=4).

Causes for iatrogenic menopause included chemotherapy, radiotherapy and surgical procedures for benign and malignant conditions. One study (Parton et al., 2017) stated that participants had undergone cancer treatment without further specifics. The focus of the studies was broad, including a general exploration of lived experience, perceived impact on relationships, emotional impact of sexual changes, quality of life, body image and identity.

Thirteen studies were qualitative, and one was mixed-method (Singer, 2012). Data collection methods were interviews, surveys, and Internet forum messages. Analysis methods used were qualitative content analysis (n=2), Interpretive phenomenological analysis [IPA] (n=1), domain analysis (n=1), phenomenology (n=1), Colaizzi method (n=2), grounded

theory (n=1) and a form of thematic analysis procedure including thematic analysis (n=3) thematic narrative analysis (n=1), thematic discourse analysis (n=1) and thematic decomposition (n=1).

Quality assessment

The methodological critique of the studies is presented below. Tables 5 and 6 provide an overview of the appraisal.

Table 5

Summary of CASP evaluation

Author and Year	Title	CASP criteria									
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Abadi et al. (2018)	Feeling an invisible wall: The experience of Iranian women's marital relationship after surgical menopause: A qualitative content analysis study	Y	Y	N	Y	Y	N	Y	Y	Y	Y
Archibald et al. (2006)	Chemotherapy-induced menopause and sexual functioning of breast cancer survivors	Y	Y	?	Y	Y	N	Y	Y	Y	Y
Boughton (2002)	Premature menopause: Multiple disruptions between the woman's biological body experience and her lived body	Y	Y	Y	Y	Y	N	Y	Y	?	?
Davis et al. (2000)	Cancer treatment-induced menopause: Meaning for breast and gynaecological cancer survivors	Y	Y	N	Y	?	N	Y	?	Y	Y
Golezar et al. (2020)	An exploration of factors affecting the quality of life of women with primary ovarian insufficiency: A qualitative study	Y	Y	?	Y	Y	N	Y	Y	Y	Y
Halliday & Boughton (2009)	Premature menopause: Exploring the	Y	Y	?	Y	Y	N	Y	Y	Y	Y

	experience through online communication.										
Johnston Ataata et al. (2020)	'My relationships have changed because I've changed': Biographical disruption, personal relationships and the formation of an early menopausal subjectivity	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Knobf (2002)	Carrying on	Y	Y	Y	Y	Y	N	Y	Y	Y	?
Orshan et al. (2001)	The lived experience of premature ovarian failure	Y	Y	Y	Y	Y	N	?	Y	Y	Y
Parton et al. (2017)	Experiencing menopause in the context of cancer: Women's constructions of gendered subjectivities	Y	Y	?	?	Y	N	Y	Y	Y	Y
Pearce et al. (2014)	Changing Bodies: Experiences of women who have undergone a surgically induced menopause.	Y	Y	Y	Y	Y	Y	Y	?	Y	Y
Pasquali (1999)	The impact of premature menopause on women's experience of self	Y	Y	N	?	Y	N	?	Y	Y	Y
Singer & Hunter (1999)	The experience of premature menopause: A thematic discourse analysis	Y	Y	Y	?	Y	N	?	?	Y	Y
Singer (2012)	'It's not supposed to be this way': Psychological aspects of a premature menopause.	Y	Y	Y	Y	Y	N	Y	?	Y	Y

Y=Yes
N=No
?=Partial/Cannot tell

Key of CASP criteria
1. Explicitly stated aims/ objectives of the research
2. Appropriate use of qualitative methods
3. Justification of the specific research design
4. Appropriate sampling strategy, description of recruitment
5. Appropriate description of data collection methods
6. Critical examination of researchers' role and bias
7. Evidence of approval by an appropriate body
8. Adequate in-depth description of analysis, rigorous data analysis
9. Clear statement of the findings, discussion of evidence & credibility
10. Research has sufficient value

Table 6

Summary of CASP evaluation by criterion

Criteria	Example	Met criterion = Partially met criterion = Did not meet criterion =													
Aims	Explicitly stated aims/ objectives of the research														14
Method	Appropriate use of qualitative methods														14
Research Design	Justification of the specific research design							7				4			3
Sampling	Appropriate sampling strategy and description of recruitment											11			3
Data collection	Appropriate description of data collection methods													13	1
Reflexivity	A critical examination of researchers' own role and bias	1													13
Ethical Issues	Evidence of approval by an appropriate body											11			3
Data Analysis	Adequate in-depth description of analysis and rigorous data analysis										10				4
Findings	A clear statement of the findings, discussion of evidence & credibility													13	1
Value	The research has sufficient value												12		2

Aims and design

All studies clearly stated their aims, but most lacked a rationale for using a qualitative methodology. However, this choice was deemed appropriate for all studies based on their aims to explore or describe personal experiences. Information provided on study design was limited, with half the studies providing no or partial rationale for their chosen method.

Participants and sampling

Most studies had inclusion criteria deemed suitable for recruiting women who had experienced early, premature or iatrogenic menopause. One study initially recruited participants to explore fertility concerns after cancer; therefore, no menopause-related

inclusion criteria were utilised (Parton et al., 2017). However, the study was included as findings related explicitly to women's experiences of iatrogenic menopause and was of high quality.

There were variations in how women's menopausal status was determined. Some studies, particularly nursing studies or those with PM populations, used medical criteria such as hormone levels (e.g. Golezar et al.,2020). Other studies allowed participants to self-identify based on specific criteria. These criteria also varied, e.g., some required women to have experienced amenorrhea (Archibald et al., 2006), whereas others included women with "menopausal symptoms" (Abadi et al., 2018). Due to this variability, studies were reviewed to ensure that their aims explicitly related to exploring women's menopause experiences and that the findings addressed these aims (see 'Validity of findings' below). Additionally, all studies met the inclusion criteria outlined in Table 3 to determine whether participants had experienced menopause early. Thus, participants were deemed appropriate for providing information on this phenomenon. Volunteer and snowball sampling was utilised, with women primarily recruited from support groups or clinical settings.

Reflexivity and ethical issues

Reflexivity was a weakness across most studies and was a notable omission where participants were known to the researcher (e.g., Abadi et al., 2018). Only two studies mentioned bracketing (Abadi et al., 2018; Orshan et al., 2001). One study considered how the researcher's age might influence participants' willingness to discuss ageing (Pearce et al., 2014). Most studies mentioned receiving ethical approval.

Data collection and analysis

All papers made their data collection methods explicit. Most used interviews and gave sufficient information on how they were conducted. The level of detail provided on data analysis processes varied. Five studies used some form of thematic analysis procedure, with only three explaining the process sufficiently. A minority made sufficient use of extracts to support their interpretations, although this could be due to editorial constraints. Due to the chosen analysis method, many of the study's findings lacked depth. Studies that adopted a phenomenological or narrative approach (e.g. Boughton et al., 2002) produced richer results.

Validity of the findings

All studies explicitly stated their findings and related these to the research aims. Three studies referenced their attempts to enhance the credibility of the results (Orshan et al., 2001; Halliday & Boughton, 2009; Knobf, 2002).

Value of research

Twelve papers met at least one criterion for judging the value of the findings. Most related their findings to existing research and identified future research avenues and clinical implications. The majority of papers addressed transferability limitations.

Overall critique

The quality of the literature was mixed. A qualitative methodology was appropriate for all papers, and the research aims were clear. Details on participant demographics varied, particularly ethnicity demographics and the age of menopause onset. Information on reflexivity was also lacking. Whilst data collection methods were explicit, transparency regarding analysis was underdeveloped. Overall, the available research was of a substantial

enough quality to justify completing a synthesis, and the implications will be returned to in the discussion.

Thematic synthesis

The thematic synthesis resulted in the development of six analytical themes. Five themes related specifically to the emotional and psychological ramifications of experiencing menopause early. These were: A psychological shift in self-perception, loss of an imagined future, isolation and wanting to belong, protecting the self through secrecy and adjustment and moving forward. One theme, relationships shape and are shaped by menopause**,** offered insights into how romantic and social relationships are implicated in women's experience of an early menopause. The data within themes were interconnected, which highlights the multidimensional consequences of this phenomenon. Table 7 outlines the themes, subthemes, contributing studies and example extracts.

Table 7

Themes, subthemes, contributing studies and example extracts

Theme	Subtheme	Contributing studies	Example extracts and quotations
A psychological shift in self-perception	Old before my time	Abadi et al., 2018; Archibald et al., 2006; Boughton, 2002; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Knobf, 2002; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	One of the women explains: "A woman with POI is like a flower withered before blooming. I feel so old; it is as if I am too old for my age. I'm not youthful anymore, I'm withered." (Golezar et al., 2020) Some women made comments about feeling old, however, on an intellectual level they knew that they were still only `young' according to social categorisation by age. (Boughton, 2002)
	My womanhood is diminished or retained.	Abadi et al., 2018; Archibald et al., 2006; Boughton, 2002; Davis et al,, 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	"I feel that as a woman . . . everything, the whole force of life is to continue itself and you're not part of that game. It takes me completely out of the realm of womanhood."(Orshan et al., 2001) "During that time I would say, I just felt less, like–less of a sexual person I guess, or less of a woman, maybe. . . . I am just a person, I am not really feminine, you know what I mean?" (Archibald et al., 2006) Leah summed it up this way. "I really experienced it [premature menopause] as a physiology issue. As a hormone issue and a surgery issue rather than an emotional [issue] or 'Who I am now that I can't get pregnant' issue." The women held on to this mindset despite a few significant others who told them, "You won't be a woman anymore." The women who were told this stated that "I just didn't take on that identity." (Pasquali, 2009)
	An altered self-body relationship	Archibald et al., 2006; Boughton, 2002; Davis et al., 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020;	"It makes me feel awful, depressed, fed up, frumpy. Before, I was really petite, skinny, and energetic." (Pearce et al., 2014).

		Knobf, 2002; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer & Hunter, 1999	This study revealed that the women who experienced menopause prematurely often became confused about the body they inhabited because physically they felt different, possibly tired and experiencing hot flushes (Boughton, 2002). "When I got my first hot flush I had to ring work, and I think I cried for the first day because I couldn't understand what was going on with my body." (Parton et al., 2017)
	An altered sexual self-concept	Abadi et al., 2018; Archibald et al., 2006; Davis et al., 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al.,2017; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	. . it's hard to be sexy when you're cranky [laughter] (. . .) to think of yourself as a sexual being when you are experiencing hot flushes every hour and you're going, 'I don't want anyone near me. All I want to do is feel cool. (. . .) (Johnston-Ataata et al.,2020) In terms of sexual identity, the women described feeling "dried up" (Halliday & Boughton, 2009)
Loss of an imagined future	Lost life plans	Boughton, 2002; Davis et al., 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al.,2017; Singer, 2012; Singer & Hunter, 1999.	". . I am too young for my life to change because I have not lived my life fully yet... love my life, my dreams and desires, and the peace it gives me, that I [sic] peace I used to have . . . I am not ready to give up those dreams and grow old. I have too much to [sic] living to do still before I settle into old age." (Halliday & Boughton, 2009) "I am so disappointed. Everyone dreams of having a baby. I cry when I'm alone and think of it …, that I cannot experience it naturally. When others are talking about children or I see a little child, I get even more disappointed "(Golezar et al., 2020)
	Loss of agency	Abadi et al., 2018; Boughton, 2002; Davis et al., 2000; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Knobf, 2002; Orshan et al., 2001; Parton et	"Even though I do not want children, the idea of not having a choice, not having that power, just really bugs me." (Halliday & Boughton, 2009

		al.,2017; Singer, 2012; Singer & Hunter, 1999	"It's the 'role' and that you should be able to choose not have it chosen for you." (Singer, 2012) "When I was supposed to have the surgery, I told myself that you won't be able to have children after this, even if you want to. I've lost my power." (Abdai et al., 2018).
	Emotional responses	Abadi et al., 2018; Archibald et al., 2006; Boughton, 2002; Davis et al., 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Knobf, 2002; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	Many women reported feeling overwhelmed and not knowing where to turn. (Halliday & Boughton, 2009) The accounts of the 12 women we describe as narratives of 'disruption and ambivalence' were suffused with profound emotional distress, frustration, ambivalence or resignation. (Johnston-Ataata et al.,2020) Based on the analysis of the interviews, the participant's experiences of the POI psychological effects included shock, grief…(Golezar et al., 2020)
Feeling isolated and wanting to belong	Feeling different to others	Boughton, 2002; Davis et al., 2000; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	Kim reflected this sense of being physiologically out-of-sync with one's age-mates, "I go to somebody's house and I see sanitary equipment in the bathroom . . . I'm thinking, . . . 'Why does she have this stuff in the house.' And then I remember she's still menstruating." (Pasquali, 1999). Many of the women talked about now being in a life stage that was not only unexpected but also inconsistent with the life stage of their peers, contributing to experiences of social isolation. (Parton et al., 2017).
	Being the only one	Abadi et al., 2018; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Knobf, 2002; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Singer, 2012; Singer & Hunter, 1999	Elsewhere in her account, Harriet described wanting to talk about POI with someone with 'more commonalities' but had not found such a person. (Johnston-Ataata et al.,2020) Most felt quite alone: "I don't know anybody else in my age group who this has happened to." (Singer & Hunter, 1999)

	Finding my tribe	Abadi et al., 2018; Davis et al., 2000; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	She found it useful to "turn to others for support from partners, friends, and other women with similar experiences." (Pearce et al., 2014) "I couldn't have managed without the support group. I was able to accrue so much info from others in the same position & health professionals who specialised in menopause who gave talks to the [YMF] group." (Singer, 2012)
Protecting the self through secrecy	Shame and embarrassment	Abadi et al., 2018; Boughton, 2002; Golezar et al., 2020; Halliday & Boughton, 2009; Knobf, 2002; Orshan et al., 2001; Parton et al., 2017); Singer, 2012; Singer & Hunter, 1999	In this study, the strategy of silence was not simply adopted just for being modest but in the sexual issues, it acted as the cover for their shyness and shame, and as a way of concealing the surgery from others. (Abadi et al., 2018) The study revealed that there is a stigma attached to owning up to being menopausal. (Boughton, 2009) "I hate it. I hate the hot flushes, I hate the sweats, I hate feeling socially, um, like an outcast, because I feel like if I'm in social circles and I start to drip it's just so embarrassing. (Parton et al., 2017)
	Keeping menopause hidden	Abadi et al., 2018; Boughton, 2002; Davis et al., 2000; Golezar et al., 2020; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al.,2017; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	"One of the problems I have with the diseases is that I have to hide it because I don't like anyone to find out about it. You need to make believe that you are fine while having it with you." (Golezar et al., 2020) "I always worry about how people will react. I'm quite cool and fine about telling people about my tumour, but the menopause I feel embarrassed about." (Singer & Hunter, 1999).
Relationships shape and are shaped by an early menopause	Relational facilitators and challenges to adjustment	Abadi et al., 2018; Archibald et al., 2006; Davis et al., 2000;	Especially in the area of sexual intimacy, our participants spoke of the importance of their partner's understanding, gentleness,

		Golezar et al., 2020; Johnston-Ataata et al.,2020; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	and willingness to change their sexual practices. (Davis et al., 2000) Negative psychological impact was ameliorated where support could be accessed, frequently from a partner, close friend or immediate family member. (Singer, 2012)
	Challenging and positive consequences	Abadi et al., 2018; Archibald et al., 2006; Davis et al., 2000; Golezar et al., 2020; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Parton et al., 2017; Pasquali, 1999; Pearce et al., 2014	After the surgery, all participants expressed relief from worry about "female bodily constraints" because none now had to worry about a menstrual cycle or birth control. (Pearce et al., 2014) Another concern for women was the feeling of emotional separation from their husbands due to the reduced sexual activity. (Abadi et al., 2018) " My sex drive is gone. Which [sic] is causing a lot [sic] of problems with my partner and I to the point that all we do is fight and have even talked about splitting up over this (Halliday & Boughton, 2009).
Moving forward and adjusting	Mental adjustment	Abadi et al., 2018; Boughton, 2002; Johnston-Ataata et al.,2020; Knobf, 2002; Orshan et al., 2001; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	Some attempted to distance themselves from their own experience by shelving 'it'. (Singer & Hunter, 1999) All participants compared themselves to others to help them to put their experiences into perspective. (Pearce et al., 2014) It (menopause) is secondary when you are going through everything else. You are dealing with a life-threatening illness and that is all you can focus on. (Knobf, 2002)
	Carrying on	Davis et al., 2000; Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Knobf, 2002; Parton et al.,2017; Pasquali, 1999; Pearce et al., 2014; Singer, 2012; Singer & Hunter, 1999	"All of a sudden it was kind of like, you're not going to have a child, and for me that was like a decision that was made that was sort of laying on me and it was just not there anymore and I said, "OK, well, I'll do something else then." . . . It was kind of a liberating feeling.... I'll do something else. I'll make—I'll create something else. I'll use my creative energies in some other way and I hope I'll create as much value." (Pasquali, 1999)

		"Probably it was made easier because I've never been geared up just to have children. (. . .) I felt that I'd done that part of my life. In fact I think my partner had the snip by then anyway. [laughter] So maybe that meant that that reflective moment was reduced in its intensity. (. . .) I don't think [my partner and I] even talked about it a lot." (Johnston-Ataata et al.,2020)
Varied opinions about the role of psychological support	Halliday & Boughton, 2009; Johnston-Ataata et al.,2020; Orshan et al., 2001; Singer, 2012; Singer & Hunter, 1999	POI, then, was an interlude in Aisling's biography, subjectivity and personal relationships, which were otherwise largely undisturbed. She, and the other women in this group, described needing little instrumental or emotional support for EM/POI (Johnston-Ataata et al.,2020). I'm starting to think that it would be nice to have children, which wasn't an issue before ... [and] to be able to talk this through from time to time. Emotional issues ... are forever changing. Access to regular professional support would be useful. (Singer, 2012)

A psychological shift in self-perception

Experiencing an early menopause had various perceived impacts on women's sense of self. These changes were experienced in four domains relating to their sense of age, female identity, sexual self-concept and relationship with their bodies. These four subthemes are described in detail below.

Feeling old before my time

Across thirteen studies, women referred to feeling prematurely old. Due to hormonal changes, some women voiced concerns about their increased risk of health problems or that their bodies had begun a change process commonly associated with older women (Orshan et al., 2001). This gave them the sense that their body was undergoing a decline incongruent with their chronological age. For a minority of women, there were concerns about external signs of ageing (e.g., Boughton, 2002). References to 'accelerated ageing' (Parton et al., 2017) and turning into a 'little grey old lady overnight' (Singer & Hunter, 1999) suggested that some women underwent a psychological shift in self-perception that reflected a shift in social categorisation from 'young' to 'old' now they were postmenopause. Some women disliked being positioned as 'old' (e.g. Parton et al., 2017). However, a few women reflected that they now had a better understanding of the experiences of older women (e.g., Pasquali, 2009).

Menopause sits at the intersection of discourses around ageing, reproduction and gender (Hoga et al., 2015). As such, authors suggested that societal narratives linking menopause to ageing appeared to be influential for some women's self-perception. This appeared to be supported by some women's accounts that they felt too young to be experiencing something associated with midlife women (e.g. Johnston-Ataata et al., 2020).

As the majority of studies contributed to this subtheme, including studies of higher quality, this suggests that this experience was not exclusive to those who experienced premature menopause.

My womanhood is diminished or retained

The apparent impact that an early menopause had on participants' sense of womanhood was identified within thirteen studies. The majority of participants across the majority of studies felt their womanhood had been diminished, with references made to not being a 'whole woman' (Abadi et al., 2018), 'incomplete' (Parton et al.,2017), and unlike 'real women' (Singer & Hunter, 1999). There was variation in the reason behind this change in self-perception. For most, this appeared to be due to their reduced reproductive capacity or infertility (Boughton, 2002). Davis et al. (2000) found this was the case even for some older women with iatrogenic menopause who already had children. Due to their infertility, some women had doubts that they would be accepted by future partners (e.g., Golezer et al., 2020).

One paper which explored the impact of sexual changes following chemotherapy-induced menopause found that a perceived loss of femininity was attributed to no longer fulfilling the expectation of being a 'functional' sexual partner capable of experiencing pleasure (Archibald et al., 2006). For others, it was hypothesised that this was more symbolic due to the loss of the 'biological tie' that binds women together (Halliday-Boughton 2009). Perceptions that they no longer fit the feminine ideal of being desirable and youthful due to body image concerns also negatively impacted participants' sense of womanhood (Parton et al., 2017.) As with the previous subtheme, authors commented that participants seemed to be drawing on discourses that constructed the menopause transition as a time of ageing and, thus, a reduction in femininity and attractiveness. A minority of participants felt their

womanhood was separate from their fertility (Abadi et al., 2018). However, these narratives were apparent in many accounts regardless of whether they adopted or rejected these beliefs

An altered self-body relationship

The experience of an early menopause seemed to change some women's experience of their bodies in two ways. The first was the perceived impact on body image which was highlighted across eight papers, with the majority of women reporting that it had been negatively impacted. Reasons cited were weight gain, undesirable changes in body shape, increased facial hair and vasomotor symptoms (e.g. Halliday & Boughton, 2009.) As noted previously, these changes appeared to alter some women's sense of womanhood, youthfulness and perceived desirability. A minority of women in one study perceived having an improved body image as they experienced minimal menopausal symptoms following a hysterectomy and an alleviation of urogenital symptoms (Pearce et al.,2014).

Secondly, due to perceived changes in physical appearance and vasomotor symptoms, women experienced a sense of disconnect between their physical bodies and psychological selves. This was highlighted across eight studies. There were descriptions of women's sense of 'control' over their bodies being altered (e.g. Archibald et al., 2006) and bodies that felt different and unpredictable (Boughton, 2002; Singer & Hunter, 1999). For some women across three studies, this sense of an unfamiliar body was also attributed to the sudden onset of menopausal symptoms after a hysterectomy (e.g. Pearce et al., 2014).

An altered sexual self-concept

A finding across eleven papers was how experiencing an early menopause influenced women's sexual self-concept. For example, women reported feeling asexual (Parton et al.,

2017) and that their identity as a ‘sexual being’ had been threatened (Johnston-Ataata et al., 2020). This shift was attributed to reasons including reduced libido and experience of sexual pleasure (Abadi et al., 2018), discomfort from vasomotor symptoms (Johnston-Ataata et al.,2020) or loss of fertility (Pearce et al., 2014). Despite occurring across the majority of studies, this experience was reported by fewer women than the previous three subthemes.

Loss of an imagined future

The second overarching theme outlined the perceived impact on women’s biographical considerations which, as outlined in the following three subthemes, appeared to centre on perceived loss and their emotional response to this.

Lost life plans

Comments by women across nine studies suggested that experiencing an early menopause had meaningful implications for some women’s sense of their futures. Some assumed they would have children so there were lost hopes of motherhood expressed in ways such as ‘dreams finished’ (Boughton, 2002) and a life ‘curtailed’ (Davis, 2000). Johnston-Ataata et al. (2020) found that for women for whom menopause was particularly disruptive, these altered futures appeared to have ongoing effects on how they viewed their current lives, with comparisons being made between their current lives and how things ‘should’ have been. Although women who had experienced premature menopause (< age 40) were the main contributors to this subtheme, grief was also felt by women who had conceived before the onset of iatrogenic menopause and wished to have larger families (Pearce et al., 2014).

Loss of agency

Across ten studies, women felt they had lost control and choice over their lives. Even women for whom infertility was not a significant concern expressed feeling powerless or

angry at no longer having the choice to conceive (Orshan et al., 2001; Boughton, 2002; Johnston-Ataata et al.,2020). Expressions of unfairness or feeling 'cheated' were common across accounts (e.g. Golezar et al., 2020).

Emotional responses

Expectedly, this loss of fertility and agency had emotional implications for women. Grief and sadness, with references to mourning, were frequent emotions and could be independent of women's parental status (Singer & Hunter, 1999). Other emotions included shock (Pasquali, 1999), anger (Archibald et al., 2006), uncertainty (Golezar et al., 2020), guilt (Singer & Hunter, 1999), anxiety (Singer, 2012) and jealousy (Halliday & Boughton, 2009).

Feeling isolated and wanting to belong

The third analytical theme outlines some women's feelings of disconnection and difference from others and their resulting desire to be with similar women to negate these feelings.

Feeling different to others

Experiences of feeling different to same-age peers and older women were featured across ten studies. Feeling 'out of sync' with peers arose from witnessing others fulfil the expected developmental task of having children (Halliday & Boughton, 2009) or contending with health concerns their friends were not experiencing (Pasquali, 1999). However, relating to older women was also challenging, particularly for those who had experienced EM or PM due to differences in age and life stage (Johnston-Ataata et al.,2020). Additionally, the company of older postmenopausal women highlighted the atypical nature of their situation (Singer & Hunter et al., 1999). These findings suggest there are relational implications for the psychological shifts in self-perception outlined in Theme 1.

Being the only one

Women across ten papers referred to the emotional challenge of being the only person they knew experiencing menopause. The rarity of this experience meant women found others could not understand or offer the emotional support they needed, contributing to feelings of isolation (e.g. Parton et al., 2017).

Finding my tribe

Women across eight studies expressed a desire to find others who had experienced an early menopause, hoping this would provide validation, solidarity and alleviate feelings of isolation (Boughton, 2002). Those who had found women in person or through online communities reported benefits (Johnston-Ataata et al.,2020). However, some voiced concern that receiving support from women who had successfully conceived prior to menopause would be emotionally challenging (Singer & Hunter, 1999). Additionally, one person expressed that being around other women with PM may exacerbate their distress (Singer, 2012).

Protecting the self through secrecy

The fourth theme describes women's attempts to maintain their self-esteem in the face of stigma, shame and concern about the judgements of others.

Shame and embarrassment

Women across nine studies referenced feeling shame and embarrassment about their menopausal status, sexual changes, and vasomotor symptoms. Premature menopause specifically was described as a 'stigmatised state' (Singer & Hunter, 1999). This shame and stigma meant that women in almost half the studies felt unable to discuss their experiences

and feelings with others. Additionally, a small number of women in two studies expressed that visible sweating contributed to feelings of embarrassment and self-consciousness (Orshan et al., 2001; Parton et al., 2017).

Keeping menopause hidden

Women across ten studies felt the need to keep their menopause secret by not discussing it with others or pretending there had been no changes. For some, cultural factors influenced this decision, as Abadi et al. (2018) found some women in Iran feared that disclosure would lead to members of their community encouraging their husbands to remarry. Such was some women's concern about keeping their menopausal status concealed, that they feared others could somehow detect their condition without their knowledge (Boughton, 2002).

Concern about negative reactions following disclosures was raised in eight papers. This made decision making about confiding in others complex (Orshan et al., 2001). One participant, who experienced iatrogenic menopause following cancer, expressed feeling more concerned about people's reaction to her being menopausal than her tumour (Singer & Hunter, 1999). Although not explicitly stated by participants, it appeared that the need to conceal contributed to the feelings of isolation identified in the previous theme.

Relationships shape and are shaped by menopause

Women's accounts across ten studies referenced the role their relationships (primarily romantic) played in shaping their experience of an early menopause. These accounts referred to both the influence of relationships on their experiences and the perceived repercussions of menopause on these relationships. Some data was interpreted by the researcher as relational facilitators and challenges to women's adjustment to their condition. Conversely, data on the

perceived repercussions on women's relationships occurred directly within women's accounts or the original authors' interpretations. These two subthemes are described in detail below. It should be noted that only two studies explored the perceived impact of menopause on relationships specifically (Abadi et al., 2018; Johnston-Ataata et al., 2020); thus, the data that contributed to this theme was notably less than the others.

Relational facilitators and challenges to adjustment

Women across nine studies spoke to factors within their romantic and social relationships that appeared to challenge their adjustment to an early menopause. Factors identified were poor communication (Davis et al., 2000), difficulty discussing changes to intimacy and making adjustments (Archibald et al., 2006), insufficient understanding and support (Golezar et al., 2020), being a new relationship (Johnston-Ataata et al., 2020), social networks' attachment to gender norms (Johnston-Ataata et al., 2020), and fear of losing their relationships (Abadi et al., 2018).

Expectedly, factors that appeared to be facilitators of women's adjustment were framed in the opposite terms. These included acceptance and understanding from their partner (Singer, 2012), good communication (Johnston-Ataata et al.,2020), and a willingness to adapt to changes in sexual functioning (Archibald et al., 2006). Additionally, partners' giving minimal significance to EM/PM within the relationship was also supportive (Johnston-Ataata et al.,2020). Regarding study quality, a high ratio of studies deemed to have 'thin' data due to the chosen analysis method contributed to this subtheme.

Challenging and positive consequences

The main challenging consequence were changes to sexual and, subsequently,

emotional intimacy, highlighted in eight papers (e.g. Abadi et al., 2018; Archibald et al., 2006).

The only positive consequence explicitly mentioned was no longer worrying about pregnancy, leading to increased 'freedom' within the relationship (Johnston-Ataata et al., 2020; Parton et al., 2017; Pasquali, 1999; Pearce et al., 2014). Notably, these accounts came from four studies featuring iatrogenic populations and may have been from women who already had children.

Moving forward and adjusting

This sixth theme outlined non-relational factors that appeared to support women's adjustment and moving forward after menopause and variations in their perceived need for psychological input.

Mental adjustment

Women across ten studies found different ways to adjust to their experiences mentally. Some cognitively distanced themselves from their situation, e.g. by 'shelving it' (Singer & Hunter, 1999). Others compared themselves to others in worse situations or focused on the positives (Pearce et al., 2014). For those with iatrogenic menopause following cancer, this perspective-taking appeared to happen organically as menopause was generally (except for one younger participant) experienced as less significant than cancer and signified their survival (Davis et al., 2000). For those with body image concerns, redefining attractiveness away from body size was beneficial (Pearce et al., 2014). It should be noted that a small number of women within each of the nine studies contributed to this subtheme.

Carrying on

For some, menopause was not a significant personal disruption, which made

continuing with their lives relatively straightforward. Johnston-Ataata et al. (2020) found that women who were older, had mild somatic changes, minimal body image concerns, and were satisfied with their maternal status were less affected. However, across five studies (e.g. Boughton, 2002), women referred to the need to redefine a sense of self and eight studies referred to coming to a place of acceptance (Pasquali, 1999). There were a small number of references on what supported this such as redirecting energies to other pursuits (Pasquali, 1999), focusing on their health (Pearce et al., 2014) and the passing of time (Singer & Hunter, 1999). However, a higher ratio of studies deemed to have 'thin' data contributed to this subtheme, thus, the studies did not fully explain what this process of acceptance and redefining the self entailed or what women found supportive for this.

Varied opinions about the role of psychological support

Expressions of support needs varied across the studies. Participants in three studies expressed a desire for professional support to support their adjustment and that this should be routinely offered (Orshan et al., 2001; Singer, 2012; Singer & Hunter, 1999). One participant reported not needing support as menopause had a minimal impact on her life (Johnston-Ataata et al.,2020).

Discussion

This review critically appraised and synthesised qualitative research on the emotional, psychological and relational experiences of women who experienced menopause early (WEME). This population included women who underwent spontaneous or iatrogenic menopause before age 45 (EM/PM) and women who had experienced iatrogenic menopause after age 45. Six analytical themes were constructed which describe the multifaceted perceived impact of this experience on women. Findings suggest women experience a shift in self-perception, along with feelings of loss and isolation. The perceived stigma of menopause

results in feelings of shame and embarrassment. Romantic relationships were perceived as being both influenced by menopause and influencing women's adjustment. Variations existed in women's perceived need to adjust to this experience and what this entailed.

These findings will be discussed and compared to existing reviews, in particular, McDonald et al.'s (2022) synthesis of quantitative, qualitative and mixed-method studies on HrQoL in women with POI, and a related thematic synthesis of qualitative research on women's experiences of POI (Hammond & Marczark, 2023). The latter was published in March 2023, when the current meta-synthesis was near completion. Six studies [1]were synthesised in both Hammond and Marczak (2023) and the current review (approximately 40% of the total studies within the current review), although the two reviews had differences in the population of focus and study inclusion criteria.

The theme **'A psychological shift in self-perception'** suggests that the women in the reviewed studies experienced disruptions in identity and self-perception, specifically in their sense of womanhood and femininity, congruence between their chronological, biological and psychological age, body image and sexual-self concept. These findings align with the theme of impaired 'ego integrity' found by McDonald et al. (2022) but expand upon these by highlighting the experience of incongruence between women's chronological age and sense of self. Many of the synthesis findings regarding women's psychological shift in self-perception corroborate Hammond and Marczak's (2023) findings. However, the current review highlighted aspects of women's experience not described by Hammond and Marczak (2023), namely, changes to sexual self-concept and feelings of disconnection from their physical body.

[1] Boughton, 2002; Golezar et al., 2020; Halliday and Boughton, 2009; Johnston-Ataata et al., 2020; Orshan et al., 2001; Singer, 2012.

The theme **‘feeling isolated and wanting to belong’** described the potential implications of this incongruence as some women faced difficulties in relating to similar-age peers and women of typical menopause age, which contributed to feelings of isolation. Although McDonald et al.’s (2022) review highlighted this isolation, the potential link between feelings of age incongruence, loss of belonging and isolation was not discussed. One assumption of Social identity theory (Tajfel & Turner, 1986) was that aspects of our social identity derive from our perceived membership to groups based on shared characteristics. An early menopause may disrupt individuals perceived commonality with both older and younger women, thus affecting their sense of belonging and possibly igniting a desire to connect with others in similar situations, as described in this review.

The theme **‘loss of an imaged future’** suggests that experiencing menopause early not only disrupts self-perception but also alters women’s future plans and sense of agency over their lives, as their imagined life trajectory is altered due to uncontrollable factors. A range of emotional responses, including grief and loss, were identified. This aspect of women’s experience was not discussed by McDonald et al. (2022) but was corroborated by Hammond and Marczak (2023).

Another psychological implication identified was the perceived need to protect and maintain one’s self-esteem from the perceived social stigma, shame and embarrassment associated with an early menopause, as well as anticipated negative reactions from others. As described in the theme **‘Protecting the self through secrecy’**, this was primarily achieved through secrecy and trying to maintain an unaltered self-presentation. Similar findings were reported in existing reviews (McDonald et al., 2022; Hammond & Marczak, 2023).

Although the current review aimed to explore the relational implications of an early menopause, only one theme, **'relationships shape and are shaped by menopause'** is directly related to this. The theme described relational factors that appeared to facilitate or hinder a woman's psychological adjustment to an early menopause. These were the level of communication, perceived acceptance and support from partners, family and friends, networks' level of attachment to gender norms and partners' adaptability to changes in sexual functioning. The main perceived negative consequence on relationships were changes in physical and emotional intimacy, with reduced concerns about pregnancy being the only reported positive consequence. The perceived importance of communication and partners' adjustment to changes in physical intimacy builds on findings from McDonald et al. (2022) and corroborates findings by Hammond and Marczak (2023). Notably, although most papers contributed to this overarching theme, these individual factors were not supported by multiple participants or studies. Therefore, these findings should be interpreted with caution.

The final theme **'Adjusting and moving forward'** captures the adjustments women made when coming to terms with their menopause. Like the previous theme, this theme was informed by fewer data and studies than other themes. For some women, an adjustment to menopause required minimal effort, while others consciously reframed their circumstances or directed their energy to alternative life pursuits. The perceived importance of the latter and the need to redefine one's identity have been expressed in previous reviews (McDonald et al., 2022; Hammond & Marczak, 2023).

Comparing these findings to studies on women's experiences of natural menopause (NM) can provide further insights into the experience of WEME. In a meta-synthesis of qualitative studies on NM experiences, menopause was also associated with ageing which led

to feelings of a loss of youthfulness and femininity (Hoga et al., 2015). Pearce et al. (2014) also highlighted negative body image effects in women with NM. However, a notable difference was that women who underwent NM also experienced it as a period of gains, such as increased wisdom, confidence and competence, as well as losses (Hoga et al., 2015). These positives were likely signs of increased maturity and self-assuredness that accompany chronological ageing. However, the current synthesis noted few positive gains associated with an early menopause. This is possibly because younger women do not experience the benefits of personal maturation that may come with ageing which could counterbalance the physiological or emotional challenges of menopause (Singer & Hunter, 1999). Additionally, themes on coping and adjustment were not as apparent within the current body of qualitative literature regarding an early menopause. The current synthesis showed that some WEME do describe needing to adjust; however, little could be elucidated about this process from the available literature.

Limitations

This synthesis adopted an inclusive definition of WEME, rather than utilising diagnostic criteria based on age and aimed to find patterns across women's experiences. While the construction of common themes across these studies suggests some shared aspects of their experiences, important differences between them may have been lost. However, efforts were made to highlight if findings appeared more relevant to specific populations to aid their interpretation. Relatedly, as outlined in the quality appraisal, there was variation across the studies in the criteria used to determine that participants had experienced menopause.

Qualitative analysis requires participants' accounts to be interpreted through the author/s subjectivities, which are then portrayed selectively within the published studies.

Therefore, it could be argued that qualitative research only offers indirect access to participants' experiences. Relatedly, reflexivity was a weakness across all studies, so the original researchers' potential influence on the study design and analysis could not be determined.

Some studies gave limited information on their data analysis process, making it challenging to ascertain how the reported themes had been generated from the original data. Most studies were conducted in Western countries with majority White populations, and non-English articles were excluded. Additionally, the reviewed literature provided limited information on the participants' ethnicities, so the ethnic diversity within the samples is unknown. It is recognised that ethnicity and sociocultural factors may influence women's experiences of NM (Hunter, 2019); therefore, there may be limitations to the transferability of the findings to women of other ethnic groups or those living in non-Western countries. The synthesis was undertaken by a single researcher, meaning their perspectives solely influenced the process and outcomes. The inclusion of other contributors may have resulted in different themes or conclusions. However, similarities between the themes of the current meta-synthesis and existing reviews gives some confidence in the analysis.

Clinical implications

This review indicates the potential for disruption in self-concept and relationships among WEME. Existing guidelines, specifically regarding PM, suggest that psychosocial support could benefit some women (Paney et al., 2020). In addition to loss and grief, the findings of this synthesis suggest other areas may be beneficial to address with a broader demographic of WEME, including those with PM. These include reducing shame, improving body image and sexual self-concept, enhancing social connections, and changes in physical and emotional intimacy in romantic relationships. Third-wave CBT interventions such as

Acceptance and Commitment Therapy, with its focus on values-based living (Hayes et al., 2003) or Compassion Focused Therapy, which aims to reduce shame towards the self (Gilbert, 2010), could support women's readjustment. Couple-based interventions to improve communication and changes in intimacy may also be helpful. However, the effectiveness of such interventions would need to be evaluated by future research. Healthcare professionals should be cognisant of these psychosocial challenges and provide information and education to assist women in coping with these issues when required. Findings also suggest that peer support may be beneficial for some women in managing feelings of isolation.

Research implications

Women's experiences of an early menopause are generally under-researched. Further in-depth qualitative studies, particularly with contemporary cohorts and more ethnically diverse samples, could deepen our understanding of women's lived experience of this phenomenon. A research gap indicated from the current synthesis with particular clinical implications is women's coping responses and adjustment processes. Using grounded theory methodology could generate theory on identity redefinition and adjustment. Quantitative longitudinal studies would be valuable for elucidating changes over time and determining if there are long-term psychosocial impacts.

Further research on the perceived impact on relationships and changes in dynamics may inform the focus for relational therapeutic interventions. Continued research on the effectiveness of different interventions could provide insights into best practice for supporting women. Additionally, further comparative research into differing populations, e.g. spontaneous vs iatrogenic, may delineate any clinically meaningful differences between these populations.

Conclusion

The review aimed to answer the question, ‘What are the psychological, emotional and relational experiences of women who experience menopause early?’ The findings revealed the multifaceted perceived impact of this experience on women, including changes in self-concept and identity, relationship with their bodies, altered relationships, and sense of belonging. The synthesis also highlighted ways women adjusted and navigated this experience. Although not all women will find an early menopause psychologically or emotionally distressing, the findings underscore the need for holistic therapeutic interventions, information and social support to be available to aid those who need it in their adjustment.

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THEMA PEART

Major Research Project

Section B: Empirical Study

Exploring UK Black women's experiences and perceptions of the menopause transition: A Reflexive Thematic Analysis

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Abstract

Objective: The menopause transition (MT) is a biopsychosocial process with the potential to impact a woman's wellbeing. There is no universal experience of the MT, and research suggests that women from different ethnic backgrounds may have different experiences. In the UK, there is a desire to enhance menopause support provision to meet the needs of a multi-ethnic population. However, there is little contemporary data on Black women's experiences. The study aimed to explore UK Black women's experience of their MT, their perspectives on the potential influence of ethnicity, and what they found helpful and unhelpful for navigating this life stage.

Method: Ten postmenopausal women were interviewed, and transcripts were analysed using Reflexive Thematic Analysis.

Results: Seven themes were developed: starting a journey with an incomplete map, a varied experience, reaching a landmark of ageing, adjusting and carrying on, seeking information and support, picking a path: HRT or going 'natural', and a time of growth.

Conclusions: Most women reported having little prior knowledge of menopause, which some found unhelpful in understanding their experiences. There was variation in the somatic changes experienced and women's responses. Most women used behavioural and cognitive strategies to adjust to these changes. Menopause was perceived as a natural life stage interlinked with Western sociocultural narratives of ageing with the potential for personal growth. Seeking information and support was perceived as helpful. Culturally competent care should recognise the range of psychosocial factors that can influence Black women's experiences and perceptions of their menopause. Healthcare professionals should be sensitive to the possibility that existing health inequalities and the potential of racial stereotyping may influence some women's perceptions of available support.

Keywords: Menopause, Ethnic Minority, Black women, Qualitative, UK

Introduction

Study overview

Variation exists in women's menopause experiences, with factors like ethnicity potentially playing a role (Melby et al., 2005.). Limited understanding of Black women's experiences in the UK may hinder efforts to provide menopause support for a diverse population. Therefore, this study explores UK-based Black women's experiences of the menopause transition, perspectives on the influence of ethnicity, and what was helpful or unhelpful during this lifestage.

Menopause

Menopause is a singular point in a woman's reproductive life stage marked by the cessation of menstruation (NHS, 2022). Following 12 months of no menstruation after her final menstrual period (FMP), a woman is classed as postmenopause (NHS, 2022). During perimenopause, the stage preceding postmenopause, women can experience physiological changes alongside menstrual fluctuations (Monteleone et al., 2018). The main changes are vasomotor symptoms (VMS), i.e. hot flushes and night sweats, but other changes are also reported, including sleep disturbances, fatigue, and musculoskeletal pain. Psychological changes such as impaired concentration, low mood, and anxiety may also occur (NHS, 2022). As these experiences can continue into postmenopause, the term 'menopause transition' (MT) is used within this thesis to encompass both the perimenopause and postmenopause stages (Pearce et al., 2014).

The menopause transition and wellbeing

Although there is no universal experience of the MT, and a causal relationship between hormone levels and non-vasomotor symptoms is disputed (Smith-DiJulio et al., 2008), these changes can affect women's wellbeing (World Health Organisation [WHO],

2022). Additionally, the MT occurs during midlife, where pressures such as caring responsibilities, work changes and health concerns may challenge coping strategies (Dare, 2011). As such, the need for healthcare to support women's psychological, social and physical health during this life stage has been recognised (WHO, 2022). Psychologists have expertise to offer in providing education and therapeutic interventions for women during their MT (American Psychological Association [APA], 2023). Whilst our understanding of the potential implications of the MT has developed, so too have the theoretical perspectives informing our understanding of variations in MT experiences.

Theoretical perspectives

Experiences of the MT have been theorised from three perspectives: the biomedical, feminist, and psychosocial models (Barile, 1997). Whilst a comprehensive account of these perspectives is beyond the scope of this paper, the biomedical model attributes menopausal changes to depleting hormones and, arguably, frames menopause as a 'deficiency disease' (Ussher, 1992). Conversely, feminist theorising considers the MT a natural process with difficulties predominantly stemming from gendered ageism (Barile, 1997). Psychosocial theorising emphasises the interplay of psychological and social factors, including mental health history, attitudes towards ageing and women's social roles (Ussher, 1992). Contemporary researchers often employ the biopsychosocial model (Engel, 1980) to conceptualise the interaction of the above factors in influencing MT experiences (e.g., Hunter & O'Dea, 2001)**.**

Literature searching revealed a lack of specific psychological explanatory theories on the MT. However, Bronfenbrenner's ecological systems model (1977) is a way of specifying the biopsychosocial model. Originally a child development theory, it has broader applications, including public mental health, and can be used to identify areas for

interventions (Eriksson et al., 2018). The framework posits that individuals exist within five 'systems' that can influence developmental processes. The *microsystem* consists of immediate environments, including family, peers, and employment context, with *mesosystems* being interactions between these elements. *Exosystems* encompass more indirect environments, such as health services and the media. *Macrosystems* capture the sociocultural context, and *chronosystems* represent individual and societal changes over time. Applied to the MT, this framework suggests that an individual's interactions with these environments, along with their biological and psychological characteristics, shape their MT experience (Fraser et al., 2023). Thus, there is diversity and variation across women's experiences. In light of this premise, qualitative research has aimed to explore women's accounts.

Women's experience of the MT

A meta-synthesis of 24 qualitative studies across Europe, North and South America, Asia and Australia found that women perceived menopause as a natural life stage associated with ageing, accompanied by personal and physiological gains and losses (Hoga et al., 2015). Women adopted strategies including hormone therapy (HT), information seeking, and physical activity to alleviate somatic changes and improve wellbeing (Hoga et al., 2015). Despite these patterns in experience, cross-cultural studies indicate that women's perception and experience of their MT varies depending on their cultural context (e.g., Nappi et al., 2021; Hall et al., 2007; Hunter et al., 2009). Therefore, country-specific studies may elucidate women's experiences specific to their country's national and sociocultural context.

Experiences of the MT within the United Kingdom

Findings from UK qualitative studies broadly align with Hoga et al. (2015), as most women perceived menopause as a natural process associated with ageing (De Salis et al.,

2018; Sergeant & Rizq, 2017; Rubinstein & Foster, 2012). Studies revealed women's increased awareness of societal narratives on ageing that link menopause to a loss of youth and attractiveness, with varying degrees of perceived impact on their sense of self (De Salis et al., 2018; Sergeant & Rizq, 2017; Rubinstein & Foster, 2012). Women felt uninformed about menopause and gave it little consideration before reaching perimenopause (Sergeant & Rizq, 2017). The MT consisted of positive and negative aspects (Sergeant & Rizq, 2017; Rubinstein & Foster, 2012; De Salis et al., 2018), with its perceived impact influenced by the intensity of physiological changes and concurrent life events (De Salis et al., 2018).

Ethnicity has also been hypothesised to influence women's perceptions and experience of the MT (Melby et al., 2005). Recent research has investigated the experiences of specific ethnic groups within a country, e.g., African-American and Latinx women in the United States, to explore potential nuances and inform the delivery of culturally appropriate care (Aririguzo et al., 2021; Cortes et al., 2021). Notably, the samples in the UK studies above consisted predominantly of White British women, potentially limiting the findings' transferability to women from Black and other ethnic minority (BME) groups (Sergeant & Rizq, 2017). Ecological systems theory-driven research on menopause suggests that ethnicity is a potential factor that could interact with one's ecological environments and influence MT experiences (Fraser, 2023 p. 31).

Furthermore, theoretical frameworks like Black Feminist Thought (BFT), posit that gender and ethnicity interplay to shape lived experience (Collins, 2000). BFT emerged to address a critique that the predominant feminist discourse did not adequately address issues of intersectionality (Aziz, 1997). BFT has influenced healthcare by informing initiatives to improve women's health literacy in Black communities within the United States (Taylor, 1998). Recently, research has concluded that integrating BFT and centring African American women's midlife experiences into menopause health promotion efforts may be beneficial for

members of this population (Aririguzo et al., 2021). Therefore, understanding the menopause experiences of UK-based Black women may offer insights with significance for their healthcare within a UK context.

Black women's experiences of the MT

A comprehensive understanding of menopause should consider the role of ethnicity (Hunter, 2019). However, Black women's experiences remain under-researched (British Menopause Society [BMS], 2023). Two UK qualitative studies have provided insights into Black women's experiences specifically. Ozuzu-Nwaiwu (2007) found BME women had a limited understanding of the health implications of menopause and lacked information to make menopause management decisions. However, insights into women's psychosocial experiences were limited. Additionally, Black and Asian women's accounts were merged, which obscured potential nuances between these groups. Wray's (2007) exploration of the influence of ethnicity on women's perceptions of midlife suggested that Black women viewed menopause as insignificant. However, the number of Black women in the sample was not specified. In contrast, recent research by Bellot et al. (2018) found that UK Black women engaged and benefited from a psychosocial menopause intervention, suggesting potential differences in the MT's significance for a contemporary cohort.

Current understanding of Black women's menopause experiences derives primarily from non-UK research, which may limit its applicability to a UK context (BMS, 2023). For example, the US Study of Women's Health Across the Nation (SWAN), a longitudinal study of women's menopause, found that Black women entered menopause earlier and reported more frequent, persistent and severe VMS than White women (Harlow et al., 2022). These findings suggest ethnicity-linked differences with social disadvantage and structural racism

hypothesised as contributing factors (Harlow et al., 2022). Although comparative research with a UK population has not been conducted, examining UK Black women's experiences appears warranted.

Rationale and aims

Some women undergoing menopause may require support, which should be accessible and effective (WHO, 2022). However, the knowledge gap regarding UK Black women's MT experiences may hinder the development of culturally informed interventions (BMS, 2023). Therefore, it is important to examine these women's experiences. Due to the likely complexity and nuance of these experiences, a qualitative approach would be appropriate. Therefore, the overarching aim of this exploratory study was to explore the perceptions and experiences of the menopause transition among a sample of UK Black women. Additionally, it aimed to explore what role, if any, the women perceived ethnicity played in their experience, and what they perceived as helpful or unhelpful for navigating this lifestage within the UK.

These aims align with the National Health Service (NHS) values of 'Everyone counts' and 'Improving lives' (Department of Health and Social Care, 2021), as the findings may be valuable for the development of statutory and community-based efforts to support UK Black women's adjustment during this transition. Given clinical psychologists' related yet distinct aims of reducing distress and facilitating positive wellbeing (Duckworth et al., 2005), the profession is well-placed to contribute to these efforts. Therefore, the findings would be of clinical relevance. This information may also be of clinical value to psychologists providing support and interventions to midlife Black women within the NHS.

Method

Design

A qualitative design was used to address the research aims. The study was grounded in a critical realist position, recognising both the biological reality of menopause and the influence of an individual's sociocultural context (Archer et al., 1998).

Semi-structured interviews were utilised so topics informed by the research aims and those raised by participants could be explored (Barker et al., 2016). A member of the target sample reviewed a draft interview schedule, and some questions were rephrased for clarity based on their feedback.

Data were analysed using Reflexive Thematic Analysis (RTA) to construct patterns of meaning across the dataset, which suited the research aims (Braun & Clarke, 2022). The inclusion criteria (Table 1) meant it was uncertain whether the sample homogeneity would be sufficient for Interpretive Phenomenological Analysis (Smith et al., 2009). Therefore, RTA was chosen as sample homogeneity is not required (Braun & Clarke, 2022).

Participants

Recruitment

Participants were recruited via purposive sampling. The organisers of three online menopause communities were contacted and consented to facilitate recruitment by circulating recruitment posters (Appendix C) via their social media platforms, online newsletter and permitting the researcher to publicise the study at menopause support groups. Participants were offered a £20 Amazon voucher for their participation.

Inclusion criteria

Inclusion and exclusion criteria are outlined in Table 1.

Table 1

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Identify as Black or mixed-ethnicity of African and/or Caribbean heritage Live in the UK Aged 46-60 English speaking At least 12 months of amenorrhea (confirmed menopause) Between 1-6 years since their final menstrual period. Lived in the UK for the 8 years leading up to their final menstrual period.	Women who had experienced early menopause before age 45 Women whose menopause was induced by a medical intervention Women who were diagnosed with a significant, long-term health condition before they reached menopause.

The exclusion criteria aimed to ensure a certain level of homogeneity of experience as research suggests these women may have notable differences in their MT experiences compared to those who experienced menopause naturally (e.g., Panay et al., 2020; Parton et al., 2017).

Ten women were interviewed which matched the sample sizes of published RTA studies (e.g. Hartley & Penlington, 2023; Spencer et al., 2022) and the data collected were considered sufficient to meet the research objectives (Braun & Clarke, 2021a). Additionally, it proved challenging to recruit more participants. Demographics per participant are outlined in Table 2.

Table 2

Summarised participant demographics

Demographics	Number
Age	
54	1
55	2
56	4
58	2
60	1
Ethnicity	
Black African	2
Black Caribbean	6
Black British	2
Year of final menstrual period (FMP)	
2016	1
2017	1
2018	2
2019	2
2020	3
2021	1
Country of origin	
United Kingdom	10
Country of residence	
England	9
Wales	1
Level of education	
Level 4 or above: First or higher degree/professional qualifications or other equivalent higher education qualifications	9
Level 3: 2 or more A-levels, HNC, HND, SVQ level 4 or equivalent qualification	1
Martial status	
Single	4
Married	5
Divorced	1
Parent	
Yes	9
No	1
Previous or current hormone therapy use	
Yes	4
No	6

Procedure and data collection

Women who contacted the researcher expressing an interest in participating were emailed an information sheet (Appendix D). Those who still wished to participate were sent a Qualtrics survey after a minimum of 24 hours to gather their informed consent and

demographic data (Appendix E). Once informed consent was received, interviews were arranged.

All participants opted for their interviews to be conducted online via videoconferencing. Due to the platform's functions, interviews were audio and video recorded. Participants who did not consent to their image being recorded were interviewed with their cameras turned off. Interviews ranged between 57-75 minutes.

Before interviews began, the information sheet was reviewed and consent was checked. Terminology relating to the MT was clarified, as was the estimated duration of their perimenopause to agree on the time period of focus. However, women's postmenopausal years were also explored. Bronfenbrenner's ecological theory (1977) informed the interview schedule (Appendix F) so attention was given to women's experiences of their MT within their ecological contexts, for example, family, work setting and healthcare services. Topics covered included women's expectations of their MT, somatic changes, perceived impact on their wellbeing and perspectives on the potential influence of ethnicity on their experiences. The rationale for asking participants explicitly about ethnicity was informed by Serrant's (2020) 'Silences Framework' for researching issues of intersectionality and race in women's health. This framework advocates that participants are given the opportunity to express their lived reality of existing within social identities that are typically under-researched, in this case, Black and female.

Ethics

Ethical approval was granted by the Salomons Institute for Applied Psychology Ethics panel (ETH2122-0113; Appendix G). Due to the potentially sensitive nature of the topic, participants were informed that they could pause or end the interview at any time. The

researcher also monitored participants' wellbeing and attended to any signs of upset. A verbal debrief was conducted after the interview for participants to reflect on their interview experience. Written debrief information was provided which included signposting to information and support for menopause and psychological wellbeing (Appendix H). Recordings were transferred onto an encrypted password-protected USB stick, transcribed shortly after the interview, and then deleted promptly. All participants were given a pseudonym, and identifiable information was changed or redacted during transcription to maintain confidentiality.

Data Analysis

Analysis followed the six recursive steps of RTA outlined in Table 3 (Braun & Clarke, 2022). Interviews were transcribed verbatim by the researcher as part of the familiarisation process. Transcripts were re-read and data relevant to the research aims were coded to capture initial meanings. Inductive coding was conducted to formulate themes from the data rather than existing theory or literature (Braun & Clarke, 2022). This choice was made due to there being limited explanatory psychological theories related to the MT (Hunter & O'Dea, 2001) and not wishing to pre-determine Black women's experiences from existing literature. Using inductive coding for a critical realist thematic analysis study is epistemologically and methodologically consistent (Finlay, 2021).

Codes were revised, which included deletion, renaming, or merging as appropriate. These were clustered according to similar content or underlying meaning, and further revisions were made. Codes were collapsed into subthemes and grouped into themes based on an underlying shared concept (Braun & Clarke, 2022). During analysis, continuous comparisons were made between transcripts, codes and (sub)themes to ensure these were

grounded in participants' descriptions. Analysis software Nvivo was used to facilitate the process.

Table 3

Steps of Reflexive thematic analysis

Stage	Phase	Brief description
1	Familiarisation	Immerse yourself in the data by listening to audio recordings, transcribing and re-reading transcripts. Brief notes on thoughts, ideas and insights are made.
2	Coding	Systematically go through data and label extracts of analytical interest or significance to the research aims with a descriptive label, or 'code' to capture the meaning and interpretation.
3	Generating initial themes	Cluster codes based on shared meaning or concept which may address research aims with the aim of constructing shared meanings across the whole data set.
4	Developing and reviewing themes	Review initial themes against the full dataset and coded extract to ensure fidelity. Themes are revised to ensure they capture the most significant patterns of meaning across the dataset, address the research aims and are underpinned by a shared concept.
5	Refining, defining and naming themes	Themes are refined further to ensure they are clearly defined, differentiated from each other and appropriately named.
6	Writing up	Writing a concise and compelling narrative which addresses the research aims.

Quality assurance

RTA requires researchers to be cognisant of how their personal experiences and assumptions may have influenced the study design and analysis (Braun & Clarke, 2021b). Before conducting interviews, the researcher had a bracketing interview to become aware of their assumptions about menopause and Black women's experiences. This process highlighted assumptions the researcher held, including menopause being a taboo topic, women may relate it to ageing, and Black women may have felt reluctant to share troublesome menopausal experiences due to internalising the 'strong Black women'

stereotype (Nelson et al., 2016). The researcher aimed to remain aware of these assumptions during interviews and data analysis to ensure alternative perspectives were considered.

Regular supervision was utilised to facilitate theme development. Supervisors assisted the author in crystallising their evolving interpretations via discussions, offered perspectives on when themes required further refinement and reflected on how themes contributed to the research aims.

Reflexivity

The researcher kept a reflexive journal throughout the study to facilitate thoughtful engagement with the data and capture how their understanding and perceptions may have informed the study. Reflections included that as the researcher belonged to the social identities of 'Black' and 'Female' and had an interest in the role of ethnicity and gender in people's experiences, this could have influenced the framing of the research aims. Relatedly, the researcher's worldview that racial categories are social constructs and are not based on physiological differences led to an assumption that the experiences of the interviewees would likely differ from those of White British women due to racialisation, therefore analytical attention may have been given to accounts relating to this. Additionally, as a healthcare professional, the researcher hoped the findings would have implications for women's experiences of healthcare, therefore interactions with health services were of particular interest and resulted in conclusions regarding patient-clinician interactions.

Consideration was also given to how the researcher's sex, ethnicity and age may have influenced participants' engagement. For example, the researcher also being a Black female may have aided rapport and a sense of safety in discussing ethnicity-related experiences, whilst being younger may have influenced their reflections on ageing. Throughout the interviews, the researcher remained aware of the need to prompt participants to expand on

their answers, ensuring they did not rely on assumptions about the participants' meanings, especially regarding ethnicity.

Results

The analysis resulted in 7 subthemes and 18 subthemes (Table 4). Each theme is illustrated using verbatim quotes from the interviews.

Table 4

Themes and subthemes

Theme	Subthemes
Starting a journey with an incomplete map	A shroud of silence around menopause
	Limited expectations and forethought
A varied experience	Changes attributed to menopause
	A variation of responses
	The intensity of changes influences the experience
	Am I experiencing something different as a Black woman?
Reaching a landmark of ageing	Becoming aware of ageing
	Resisting or adopting the ageing narrative
	A turning point into healthy ageing
	Making the most of my time left
Adjusting and Carrying on	Carrying on
	Mental adjustment
	Perceived impact of racism on adjustment
Seeking information and support	Informing myself
	Menopause as a shared experience
Picking a path: Hormone therapy or 'going natural'	Taking the natural path

Changing route from natural to HT

Concerns about racial discrimination in healthcare

A period of growth

Starting a journey with an incomplete map

This was a central theme where all women described being exposed to limited conversations about menopause before entering perimenopause. They felt this resulted in them having limited knowledge and expectations about the MT and giving it minimal consideration. Their descriptions gave the impression of starting a journey with an incomplete map, where one knows their destination but has a limited sense of what they may encounter.

A shroud of silence around menopause

All women said there had been limited conversations about the MT before their perimenopause amongst their families, friends, peers, or broader society.

"*It wasn't on my radar, in terms of my friendship group, we weren't talking about it, in terms of my mother, we never talked about it." (Amaka)*

Women offered reflections on why this may have been, including menopause being a "taboo" topic in society (Amaka), women's reproductive health not being discussed amongst some African Diaspora communities (Joss, Amaka, Beverley) and previous generations' lack of information and understanding about menopause (Carol, Brianna).

Some of the women found this lack of discussion unhelpful as they had limited or incorrect information from which to understand their experience.

"I think because there wasn't that openness about menopause within the women of our family, with our aunties, uncles or anybody like that, then it can become 1. A taboo subject 2. You get misinformation, and 3. You're left ignorant, and it just comes upon you and you don't really know what's kind of happening." (Carol)

Limited expectations and forethought

As a consequence of the perceived silence around menopause, the majority of women felt they had limited expectations about the MT, with menstrual changes, hot flushes and mood swings being the most common anticipated changes**.** Several women did not know there was a perimenopausal stage and assumed that the end of menstruation would mark the beginning of their MT. For Joss, this meant she did not attribute hot flushes to her starting her MT.

"I didn't relate it [hot flushes] to the menopause because obviously, I didn't know that there was such a thing as perimenopause... because I was still having periods, I didn't think I was going through anything to do with the menopause at that time." (Joss).

It also appeared that having few prior expectations meant women did not consider their approaching MT and assumed it would be unproblematic. A small number believed the lack of discussion from older generations, as described in the previous subtheme, implied it was a simple transition. Mindy's quote below demonstrates the interconnection between these subthemes.

"My expectations would be that it would come, I would get over it, and then I'd move on. So there were no expectations about what I would experience. It wasn't mentioned, was it?" (Mindy)

A Varied experience

Women's experiences of their MT varied due to experiencing different somatic and emotional changes. Their emotional and cognitive responses also differed. Some women spoke to the potential existence of differences based on ethnicity.

Changes attributed to menopause

Women attributed various physical changes to their menopause, including menstrual changes, VMS, brain fog, hair thinning, libido changes, sleep disruption, tiredness and weight gain. Emotionally, they noted increased anxiety, irritability, and low mood. Some women ascribed changes to perimenopause retrospectively, either due to not understanding them as menopausal changes or attributing them to other reasons such as stress.

A variation of responses

Women had a range of cognitive and emotional responses to these embodied changes. Some women (Amaka, Dee, Joss) thought they were less attractive due to weight gain and hair thinning. Body changes and libido changes resulted in feelings of sadness and a loss of control over their bodies. Others voiced concern about others' judgements about them sweating, which made them feel "embarrassed" and "self-conscious". The end of menstruation was met with relief, a sense of poignancy and/or loss, as well as positivity due to freedom from the possibility of pregnancy.

The intensity of changes influences the experience

Consistent with the expectations expressed in the first theme, the majority experienced minor or gradual changes which had a minimal impact on their quality of life. However, two women found their MT more troublesome due to the perceived intensity and duration of the changes.

"It's been a negative impact on me because also the reaction. I've not just been somebody who had a few heavy periods and sweated and that was it and moved on." (Dee)

Am I experiencing something different as a Black woman?

A small number of women spoke to the possibility that Black women's menopause experiences might differ from women of other ethnicities. For Femi, this was expressed with uncertainty and curiosity; for Sade, she appeared to be repeating something she had heard.

" I do it [talking] with a lot of my colleagues at work who are White and when we talk about our different experiences, I never think about ohh because they're White and I'm Black the experiences will be way, way different. But I would also have loved to have a support group for Black women that talk about these things and kind of [pause] peculiarities to kind of Black women or [pause] I don't know."(Femi)

"It's said that we do go through the menopause differently to our White counterparts…"(Sade)

A few women explicitly stated a need for support tailored to Black women.

"I think there needs to be some tailored support out there for women of colour because we do, we voice things differently and we are more vocal in certain areas and I think because probably our upbringing is very different to our White counterparts and other ethnicities, I think there needs to be more tailored around our experiences." (Sade)

Although reasons for these potential differences were not expanded upon during the interviews, their comments allude to the possibility of an ethnically nuanced experience not yet fully understood. Although all women had the opportunity to reflect on whether they thought ethnicity played a role in their MT, not all felt it was relevant to their experience. Others expressed a sense of it not being easy to know. A possible reason for this is that this required participants to know or imagine the experiences of women from other ethnicities from which to compare to their own, which may have been challenging. However, some participants did offer reflections on this, particularly their perceptions of how their ethnicity did or could influence how others treated them. It could be that these were examples where the influence of ethnicity was easier to 'know', which may explain their occurrence in later subthemes.

Reaching a landmark of ageing

Although physiological and emotional experiences varied, most women perceived menopause as a marker of ageing, prompting an awareness of sociocultural narratives around ageing, attempts to counteract physical decline and embrace their remaining years.

Becoming aware of ageing

The majority of women made explicit or implicit references to the menopause transition having instilled an awareness of time passing and their ageing. Thus, menopause appeared to be a marker between their former younger years and an 'older' lifestage.

"It's that thing where you are like, right, you notice the next phase of your life is coming don't ya? So you are moving onto ageing…" (Sade)

As menopause was equated with ageing, its implications for women were inextricably linked to societal views on ageing, notably reduced attractiveness, societal value and physical decline. Although some women appeared to cite these narratives without identifying with them, it seemed that an awareness of their ageing was accompanied by an awareness of these narratives.

"But I guess it's also how the media portrayed it all during the course of my lifespan and prior to that. Menopause is you're getting old, you're on the shelf, you don't look attractive, you don't do this or do this." (Danai)

Relatedly, Dee spoke of perceiving the term 'Auntie', a term of endearment and respect for older Black women within some Black communities in the UK and USA (Perry, 2022), as dismissive.

"That term 'Auntie' you know that I hear now. I didn't hear when I was growing up, it's sort of got an endearing aspect to it but it's also like 'silly old bugger, go sit down'."(Dee)

Resisting or adopting the ageing narrative

Although most women were aware of these narratives, women varied in how these societal narratives influenced their sense of self during their MT. Some women reported

feeling ‘old’ or a loss of youth at some point during their MT, whilst others conveyed a sense of actively resisting these narratives.

“I think sometimes we project things onto our lives and we take those things on, like I’m getting old, you know? And I just sort of think no, I’m getting younger….I say because I’m getting younger because I feel that if you start labelling yourself it’s like a self-fulfilling prophecy, you know? You’re gonna get old. And I don’t feel old. I don’t feel, you know, like I have to behave a certain way. I don’t look 56 according to myself and according to other people.” (Brianna)

For Brianna, her sense of not feeling old appeared to be supported by not looking ‘old’. In contrast, Dee, who noted visible signs of ageing, “[my] *face is kind of falling down”* had a stronger identification with being “old”, suggesting a link between feeling “old” and the perception of an ageing body.

“I feel like I just need to get my 100 caps and go live on a hill. You know, that kind of old Crone that takes herself away.”(Dee)

A turning point into healthy ageing

For most women, the MT was also a time to adopt health behaviours such as exercise and diet changes. Although these were seen as helpful for managing menopausal changes for a few women, the primary motivation for most was to circumvent age-related ill health or decline.

"So just living my life as healthily and actively as I can to help me in later years, so I maybe don't have conditions that can debilitate you as you get older." (Joss)

In some accounts, there were undertones of menopause being a threat to physical health. For Amaka, this appeared to be the latent message from a health professional. *"That [the importance of staying healthy] was very much part of the information that came to me. It wasn't specific, but it was about optimising your health because once you hit that menopause, you know, we really need to look after ourselves..." (Amaka)*

Making the most of my time left

Some women found their MT prompted self-reflection on how they had spent their younger years and inspired a renewed resolve to embrace life in their remaining years. This involved stepping out of their "comfort zones" and pursuing hobbies and interests, which was experienced as positive for their self-perception.

"*I came to a point where I just thought I'm gonna do things now because I really felt that in my younger years that I prevented myself from stepping out and trying different things." (Brianna)*

"I haven't done anything. I've sat back and let life pass me by without doing certain things, and it's like I don't want that. I want to enjoy everything now and keep doing it so that when I get to retirement, I've embodied loads." (Sade)

Adjusting and Carrying on

Most women spoke of continuing through daily life alongside menopausal changes which was supported by them adopting certain mindsets. The perceived impact of racism and racial stereotyping on their adjustment was also raised.

Carrying on

Most women spoke of needing to continue with daily life alongside menopausal changes using terms like "put up with it" (Amaka), "get out there and get on with my life" (Joss) and needing to "act normal" during hot flushes (Mindy). This was particularly the case when women were at work. For some, experiencing mild changes aided this. Others did not pay much attention to these observed changes due to other priorities, so did not seek advice or information.

"I was kind of going up my career ladder, being promoted and focused more on work…So what was happening with my body was kind of like a secondary attention….so I didn't go to the doctors or anything." (Femi)

Mental adjustment

Nearly all women described a particular mindset to help them manage menopausal changes. Many women saw the MT as a "natural stage of life" (Femi, Joss, Danai, Carol, Brianna, Beverley) which supported a position of acceptance or resignation about the changes. Others reported trying to stay positive or adopt a resilient mindset. One woman considered the influence of her cultural upbringing in adopting a mindset of acceptance and resilience.

"I don't know if that's my upbringing in Africa, you know, be a tough cookie and say yes life is a battlefield anyway you just have to go through it and make sure you make the best of it." (Femi)

Two women described cognitively reframing their initial thoughts about VMS to support their ability to carry on with their lives. For Joss, she could do this once she attributed her sweating to menopause.

"The first couple of times, I was self-conscious, and I thought people are staring at me and would talk about me and think I'm a strange sort of person, …and then now when it happens I just think, well, I'm in the menopause, there are thousands of women, you know, who are probably going through the same thing as me."(Joss)

Perceived impact of racism on adjustment

For a minority of women, perceived experiences of racism negatively affected their adjustment in some way. Sade felt that the lack of support she received from an employer due to a display of heightened emotion, which she attributed to perimenopause, was possibly influenced by racial stereotypes.

"When it comes down to women of colour, I think we are perceived as being quite aggressive and it's that thing where nobody is putting the actual two together, that it's the menopause, low mood, is this some anxiety or depression, what else is going on? They are not putting all that together and linking it. They are just saying 'Oh there, that's an angry Black woman". That's it. Nothing more." (Sade)

For Dee, perceived race-related events in her personal life and society were experienced as additional stressors to manage alongside her MT.

"The George Floyd thing that happened and all of that…I don't know if it's because of where I'm at in my life's journey, or whether you just kind of get to a point because I'm 55, that you just think I've seen this too much …. I also had a massive amount of stress at work because I took out a grievance for racism. So, you know, as well as being menopausal, I was also doing a lot of fighting, just about trying to exist, and be heard, then trying to be heard as a woman, then been trying to be heard as a Black person. It's been a lot." (Dee)

Seeking information and support

Unsurprisingly, due to the women's perceived lack of knowledge about menopause described in the first theme, accessing information and sharing menopausal experiences with other women was perceived as helpful. Many found this primarily occurred postmenopause when the recent societal interest in menopause increased the information available and opportunities for peer engagement.

Informing myself

Almost all women emphasised the importance of seeking information on menopause, including physiological changes, potential health implications and management methods for navigating their transition. This was done primarily via the Internet and menopause groups. Few consulted their GPs for information. For some women, self-education appeared to induce confidence when advocating for themselves during GP visits.

"I just make sure that I'm clear and I've got the knowledge and the backup behind me. And so if I want to say no or say no, actually you haven't been listening to me, this is what I'm saying, this is what I need…. It's quite empowering in a way that you've got that knowledge behind you." (Amaka)

Whilst most found controlling their information acquisition beneficial, a few individuals spoke of the challenge of identifying credible information online.

"There's lots of it and there are lots of people saying they are experts..."(Sade)

Menopause as a shared experience

Women found discussing menopause with peers and sharing experiences helpful. Some noted that these discussions only began upon reaching perimenopause age or experiencing changes, possibly due to its relevance and immediacy.

"I would say that once we were in the perimenopause, that's when we've been talking about it but leading up to it, not at all." (Amaka)

Over half the women participated in menopause groups and spoke positively of the practical and emotional support they provided and the sense of solidarity.

"I'm not alone. It just gives me a lot of reassurance. Just helps me to cope better knowing that." (Femi)

Groups were particularly beneficial as an alternative to medication.

"I don't know whether or not there's anything that a GP could do for me apart from if there's any medication, put me on medication, which I do not want to go on, so I'd prefer to talk to

people and join groups to speak to women who are going through what I'm going through." (Joss)

In contrast to those who found peer menopause spaces supportive, Dee spoke of concern about attending a predominately White menopause space after feeling dismissed when raising the potential impact of ethnicity on the menopause experience. It appeared the group's response to her highlighting this difference fractured Dee's sense of belonging in this space, eliciting a sense of alienation or Otherness.

"I don't really wanna go back now just because I am the only Black woman there [redacted]. I'm already thinking I don't know what you're about. You might, you might not understand that, you know? So I feel- it's like standing out all the time…I'm very aware of being Black and being a Black older woman and how that is sometimes perceived by people." (Dee)

Picking a path: Hormone therapy or 'going natural'

The decision whether to take HT or not was a part of each woman's MT and involved the consideration of symptom severity, personal views of medication, peer and family opinions and perceptions of the NHS.

Taking the natural path

Those who decided not to take HT cited reasons including a lack of necessity due to mild somatic changes, preference for natural methods, concerns about side effects, and not wanting to interfere with the body. A small number cited the previous generation's ability to cope without HT as confirmation that it was not required.

"I'm a great believer of the previous generation went through it, they survived, I should survive."(Femi)

Changing route from natural to HT

The minority taking HT also spoke of an initial preference for natural methods. However, they opted for medication due to their ineffectiveness at relieving somatic changes and a desire to improve their quality of life and function better at work. Thus, HT contributed to their 'Carrying on' described in a previous subtheme. Conversations within society and their networks influenced their decision.

"But I was heavily influenced by, I would say, the things in the media, how I was feeling, also going to the support group and other sort of women's meetings where menopause was being discussed." (Mindy)

For a few individuals, taking HT was not simply an individual health management issue but also had implications for their sense of identity within their peer networks.

"I suppose with some of my Black female friends that they, a lot of them are just doing it naturally and so I kind of felt, God, I'm really going against the grain of their beliefs, you know?... So I did feel that that was tricky for me. Just being different in that in that respect."(Amaka)

Concerns about racial discrimination in healthcare

Mistrust of healthcare services based on perceptions or experiences of racial discrimination was raised as a potential obstacle in engaging with healthcare services. Two women (Dee and Amaka) mentioned their awareness of health disparities regarding Black women's reproductive care as a consideration in their engagement with health services and the decision to take HT.

"I do feel that Black women's health in Britain, you know, we're not, we're not looked after. You hear the most horrendous stories about what happens to women in health. I mean, I had two awful births, awful births. I'm lucky to be here. And I suppose there's that lack of trust in what's being said to you, what's being offered to you…" (Amaka)

Both raised concerns about negative assumptions health professionals may make about them as Black women. For Dee, this followed an interaction within her GP practice regarding Black women's experiences in the healthcare system.

"I did this complaint and within the complaint I also said, you know, given that Black women and our experience within health is negative, blah blah, blah. The response from [redacted], they went ***off!*** *"How dare you use such inflammatory language?! "So even when you tell people the facts that's what happens [a negative response]. So I'm frightened now of my GP."(Dee)*

A period of growth

The majority spoke about their MT as a proxy for a passage of time during which positive personal growth had occurred, akin to maturity. This growth manifested as increased self-confidence, personal strength and authenticity. Some became more "vocal" and able to "speak up" in both their personal and professional lives. For three women (Amaka, Brianna, Beverely), their increased authenticity was reflected in feeling more secure in their Black female identities, with Beverely deciding to wear her hair in its natural state (not chemically processed) after years of feeling the need to "conform to White society". For both women below, reaching a place of security in their racial identity was seen as an achievement as an ethnic minority in the UK.

"The fact that I have natural hair that really wouldn't have been me. So, I would say this is all part of my journey… I've got the natural look. I am so confident in who I am and what I stand for as a Black woman." (Beverley)

"A lot of it for me has been about confidence and being able to feel, you know, very much vocal about what is right for me and not what everybody else is telling me what to do. And that has been partly to do with feeling more confident as I've transitioned from being perimenopausal to menopausal … Living here in, living in, you know, sort of White Britain. For me, that's a really big deal. Instead of feeling that I'm not seen, I'm not heard. I can't be my authentic self. But I do feel like I am now." (Amaka)

Discussion

This study explored UK Black women's perceptions and experience of their menopause transition (MT) whilst examining their perspectives on the potential influence of ethnicity and what was helpful and unhelpful for navigating this life stage. Key findings were that the MT was perceived as a life stage associated with ageing and women had varied experiences. Regarding ethnicity, some women reported feeling more secure with their Black identity postmenopause, and that the prospect of being racially stereotyped influenced their expectations of the support they may receive from employers or health services.

Consistent with conclusions from existing research (e.g. O'Reilly et al., 2022), many participants had limited knowledge of the MT and few expectations for their perimenopause. Echoing findings from a UK study with a sample of BME women, some reported minimal family discussions about the MT (Ozuzu-Nwaiwu, 2007). For some women, a lack of conversation in their microsystems (families and peers) and exosystems (wider society)

appeared to have led to an inadequate understanding of menopausal changes and how to identify them in themselves.

The theme ‘A varied experience’ brings nuance to Wray’s (2007) conclusion that Black women perceive menopause as insignificant. Findings suggest its significance was shaped by the somatic and emotional changes women experienced, their attitudes towards them and perceived impact. Many recalled both positive and challenging aspects, which mirror findings from predominantly White British samples (e.g., De Salis et al., 2018). The more challenging aspects were also consistent with existing findings that the MT is associated with impaired body image (Pearce et al., 2014), embarrassment about VMS (e.g., Sergeant & Ritq, 2017) and mood changes (e.g., George, 2002). Furthermore, the study’s findings align with extant conclusions that most women find ways to adjust to these changes through behavioural and cognitive strategies, including lifestyle changes, taking HT and a mental position of acceptance (Hoga et al., 2015). Some women’s instinctive reframing of their initial responses to VMS supports the utility of reframing negative appraisals about somatic changes, which underpins cognitive behavioural interventions for menopause (Ye et al., 2022).

Many women perceived menopause as transitioning into an older life phase, which corroborates existing literature with majority White British samples (e.g., Sergeant & Rizq, 2017). The accompanying awareness of Western societal narratives that equate ageing with reduced attractiveness, social value and physical capacity was also expressed in studies with primarily White British women (e.g., De Salis et al.,2018). These observations support the idea that menopause narratives are socioculturally formed and can span across ethnicities (Hall. et al., 2007). Notably, no participant expressed feeling positive about ageing due to

African-Caribbean cultural views on the value of older women, as is sometimes suggested in menopause literature (e.g., BMS, 2022). Thus, in efforts to provide 'culturally competent' care, HCPs should avoid making assumptions about Afro-Caribbean cultural values and acknowledge the potential cultural influence of UK Black women's microsystems, exosystems and macrosystems.

The presence of these narratives in women's accounts, despite varying levels of identification, illustrates their pervasiveness and potential influence on attitudes towards menopause. Levy's 'stereotype embodiment theory' (2009) suggests that ageing stereotypes can be internalised and shape attitudes and behaviours in midlife adults as they age. Some participants' resistance to these narratives seemed like an attempt to hinder this process. Relatedly, adopting health behaviours to slow physical decline aligns with the concept of 'successful ageing' (Rowe & Kahn, 1997) and suggests taking responsibility for one's health resonated with some women.

Some women's perceptions of their MT as a time of personal growth corroborates existing findings where women perceived an increase in confidence (Perz & Ussher, 2008), authenticity (Sampselle et al., 2002), and sense of transformation (De Salis et al., 2018) across their MT. However, this might be more attributable to midlife development than the MT itself, as similar reflections arise in midlife studies more broadly (e.g., Arnold, 2005). This study adds to these findings with reports of increased security in one's Black female identity. Existing developmental theories, critiqued for being biased towards White males (Juntunen & Bauman, 2012), may offer a limited understanding of this finding. However, Jung (1933, cited in Lachman, 2001) theorised that midlife was a distinct life stage with the potential for personal growth. Additionally, Black identity development theories suggest the

potential for a deepening positivity towards one's racial identity over time (e.g., Hardiman & Jackson, 1997). It is recognised that women's midlife has been under-theorised (Lachman, 2001). Thus, although only a few participants reported this shift, further research through an intersectional lens could facilitate an understanding of UK Black women's development and perceived self-growth in midlife, which could aid contemporary developmental theorising in this area.

Regarding what women found helpful for navigating their MT, information-seeking led to a better understanding of changes associated with menopause, potential health implications and management strategies. Conversely, the lack of this information earlier in their lives was the only factor explicitly stated as unhelpful. Contrary to findings by Ozuzu-Nwaiwu (2007) that BME women had insufficient access to information to inform management decision-making, the women within this study appeared to have adequate access, suggesting temporal changes in information availability. Although helpful for some, others supported Arseneau et al.'s (2021) conclusion that the abundance of online information made identifying trustworthy sources challenging.

Peer connections for practical and emotional support were perceived as helpful, aligning with theories which identify support as a key component for successful adjustment during transition periods (Schlossberg et al., 1995). An atypical finding was women's engagement in community menopause groups for this support, whose provision seemed driven by the recent societal interest in menopause. This finding reflects Velez Toral et al. (2014) conclusions that group psychosocial interventions have potential therapeutic benefits and, thus, could be an exosystem-level intervention.

One consideration regarding the role of ethnicity in these women's MT experiences is that these groups were attended predominately by Black women. While interviewees did not highlight ethnicity as a key factor in their group experiences, research on a menopause psychoeducation group targeted at Black women suggested that attendees' shared ethnicity may be important for engagement (Bellot et al., 2018). Perhaps relatedly, one participant's account suggested that neglecting to address ethnicity-related issues may have implications for Black women's sense of belonging in mixed-ethnicity menopause spaces.

Interviewees' own perspectives on the influence of ethnicity varied. Most did not consider ethnicity relevant to their experience, whilst a small number felt that being racially stereotyped had the potential to affect the support and understanding they received from employers or health services. Although women in studies with predominately White British women also voiced concerns about receiving insufficient support from health services during their MT (e.g., Sergeant & Rizq, 2017), their ethnicity was not reported as contributing to their concern. In contrast, African-American women expressed concerns about the support they may receive in health services during their menopause due to their ethnicity (Aririguzo et al., 2021). Thus, the possibility of racial discrimination may influence some UK Black women's perceptions of health services. Additionally, whilst participants shared a common ethnicity, there was cultural heterogeneity within the sample. Variations in aspects such as faith and country of origin might have influenced women's perceptions of their MT and how they navigated this.

Limitations

The small sample size was appropriate for the study's scope and analysis method (Braun & Clarke, 2022). However, UK Black women are a heterogeneous group, and the findings cannot represent the full diversity of MT experiences among this population.

Although the study did not aim to produce generalisable results, some sample characteristics may limit the findings' transferability to a broader demographic of UK Black women. Firstly, the majority of accounts were from women who did not experience their MT as problematic. Most women had a high level of education which is associated with higher socioeconomic status and general health which can positively influence women's MT experiences (Namazi et al., 2019). Lastly, the sample consisted of postmenopausal women; therefore, their experiences may differ from a contemporary cohort of perimenopausal women.

Implications and future directions

This study suggests the MT had some significance for some UK Black women, underscoring the need for accessible and reliable information. Previous researchers, based predominately on White British women's accounts, recommend this information be holistic to reflect the multifaceted nature of women's MT (e.g., Sergeant & Rizq, 2017). This study supports this recommendation and helps extend its transferability to UK Black women. As MT experiences were intertwined with personal growth, attitudes towards ageing, and health behaviours, bringing a psychological perspective to menopause information could benefit some members of this population. Clinical psychologists, given their breadth of training, are well-positioned to support the development and dissemination of such information (APA, 2023). Evidence-based self-help resources, consulting and training for medical HCPs, and

psychoeducation sessions are viable methods and align with NICE recommendations that women have access to menopause information in various ways (NICE, 2015).

Healthcare services could consider signposting women to existing community-based menopause groups. Relatedly, research into UK Black women's experiences of community-based psychoeducational groups, their efficacy and beneficial components may be warranted. As the MT was a pivotal time for engagement in healthy lifestyle behaviours for some women, targeted public health initiatives for midlife Black women may improve long-term health outcomes (Infurna et al., 2020).

In providing 'culturally competent' menopause care, the potential influence of Western narratives on UK Black women's experiences should not be underestimated. HCPs should also be aware that the existence of racial stereotyping and health disparities may influence perceptions of support among some UK Black women. Sensitivity to this may foster clinician-patient alliance (Williams & Jackson, 2019).

Conclusions

The study's findings suggest that the MT is a multifaceted experience for some UK Black women. There were variations in the somatic and emotional changes experienced and women's responses. Many felt they lacked knowledge about the MT, and peer connections were important for emotional and practical support. Culturally sensitive care should acknowledge the influence of women's microsystems and macrosystems on their MT experiences. Employers and HCPs should be cognisant that health inequalities for Black women and the potential of racial stereotyping may influence some women's perceptions of support.

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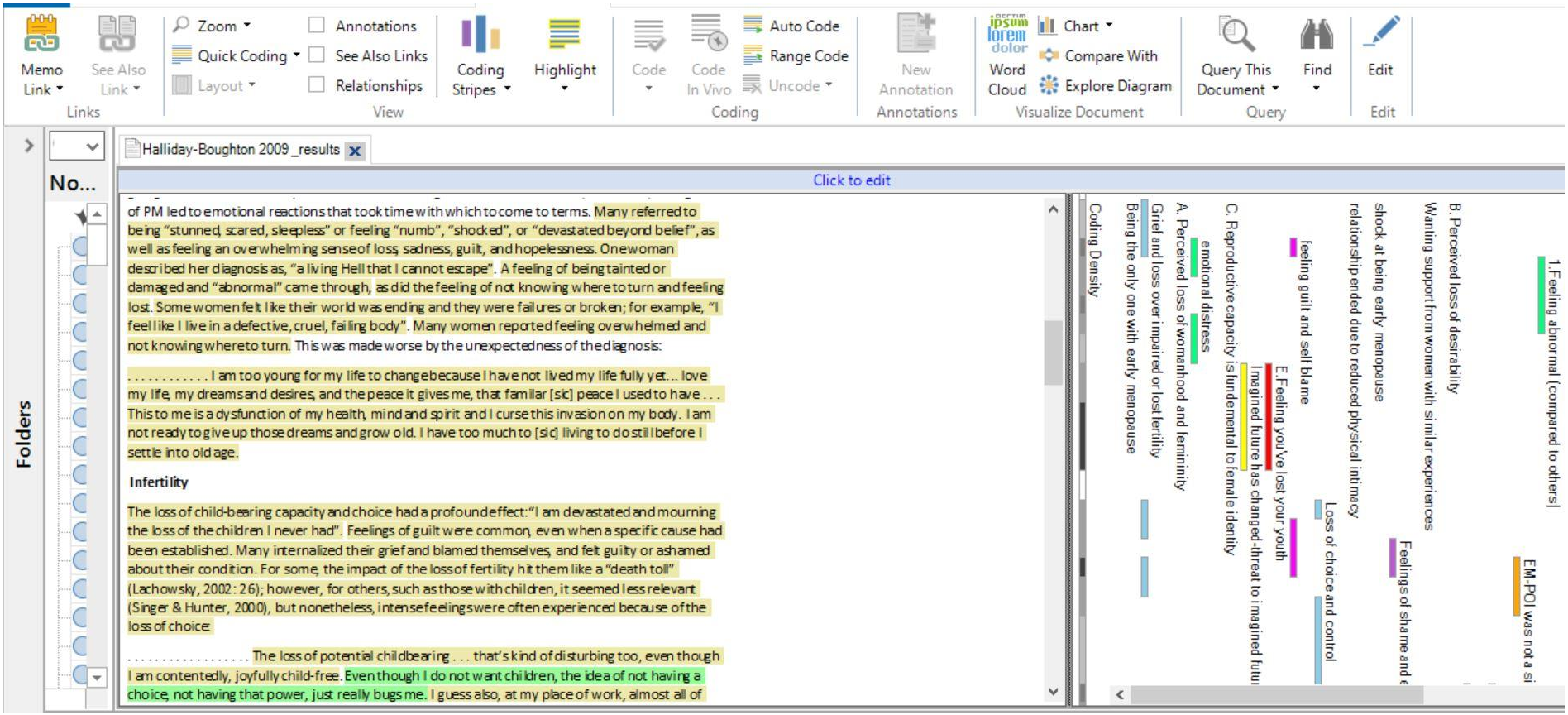
Part C: Appendices

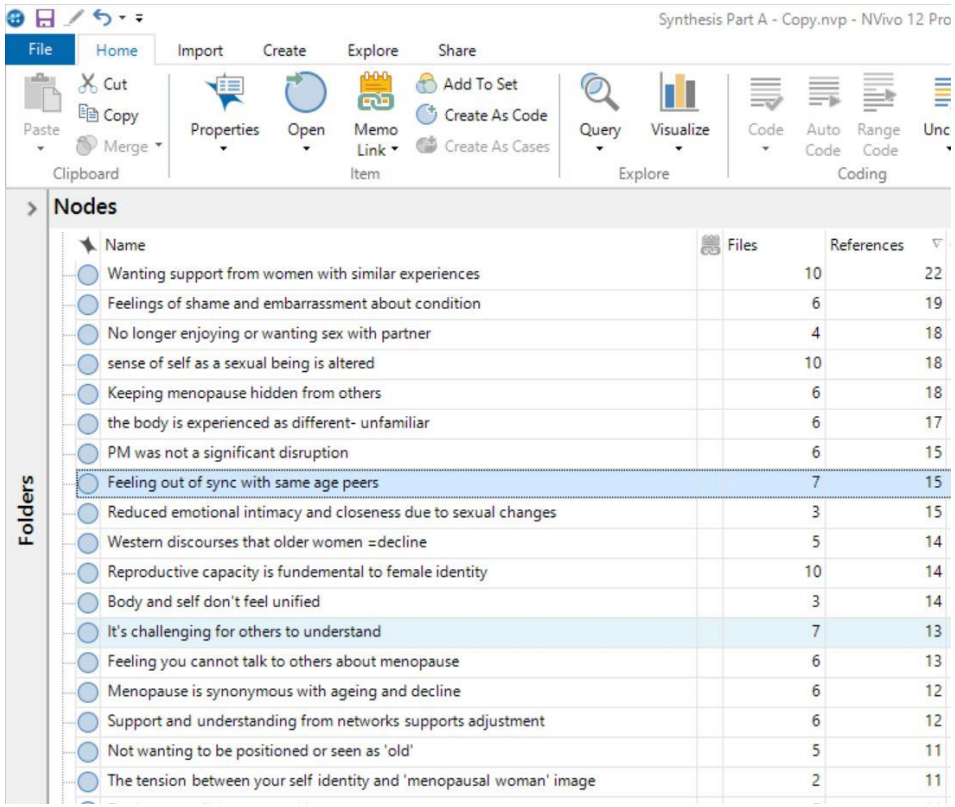
Appendix A: Critical Appraisal Skills Programme Tool

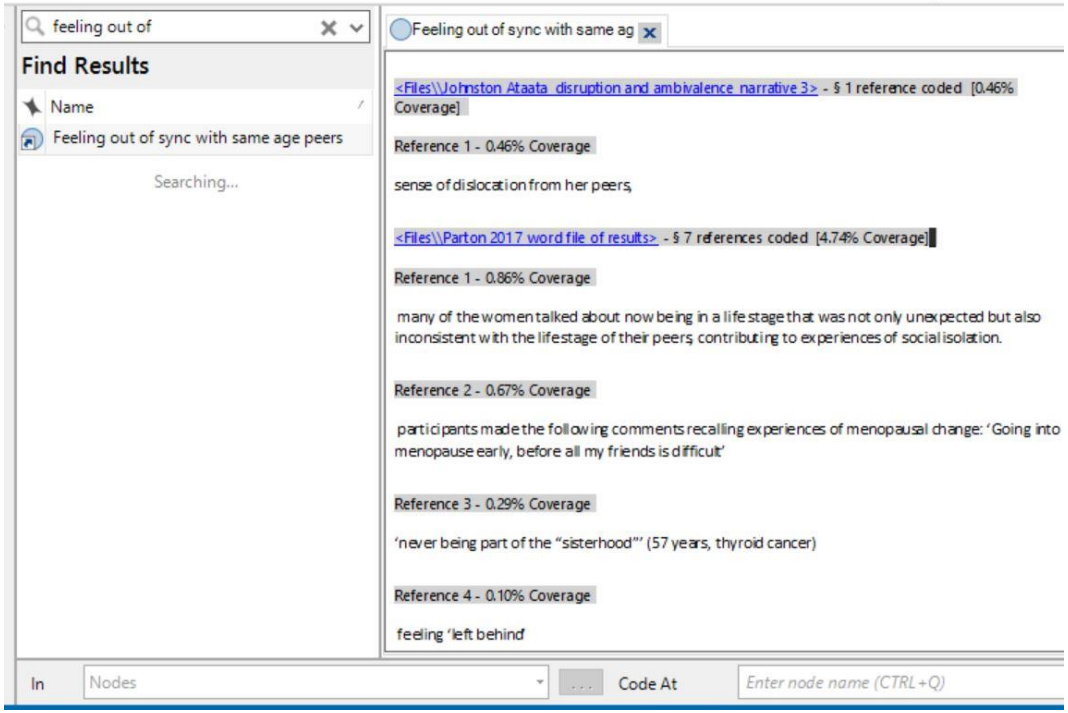
The CASP tool for Qualitative studies can be found here https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Appendix B: Evidence of meta-synthesis process (Part A)

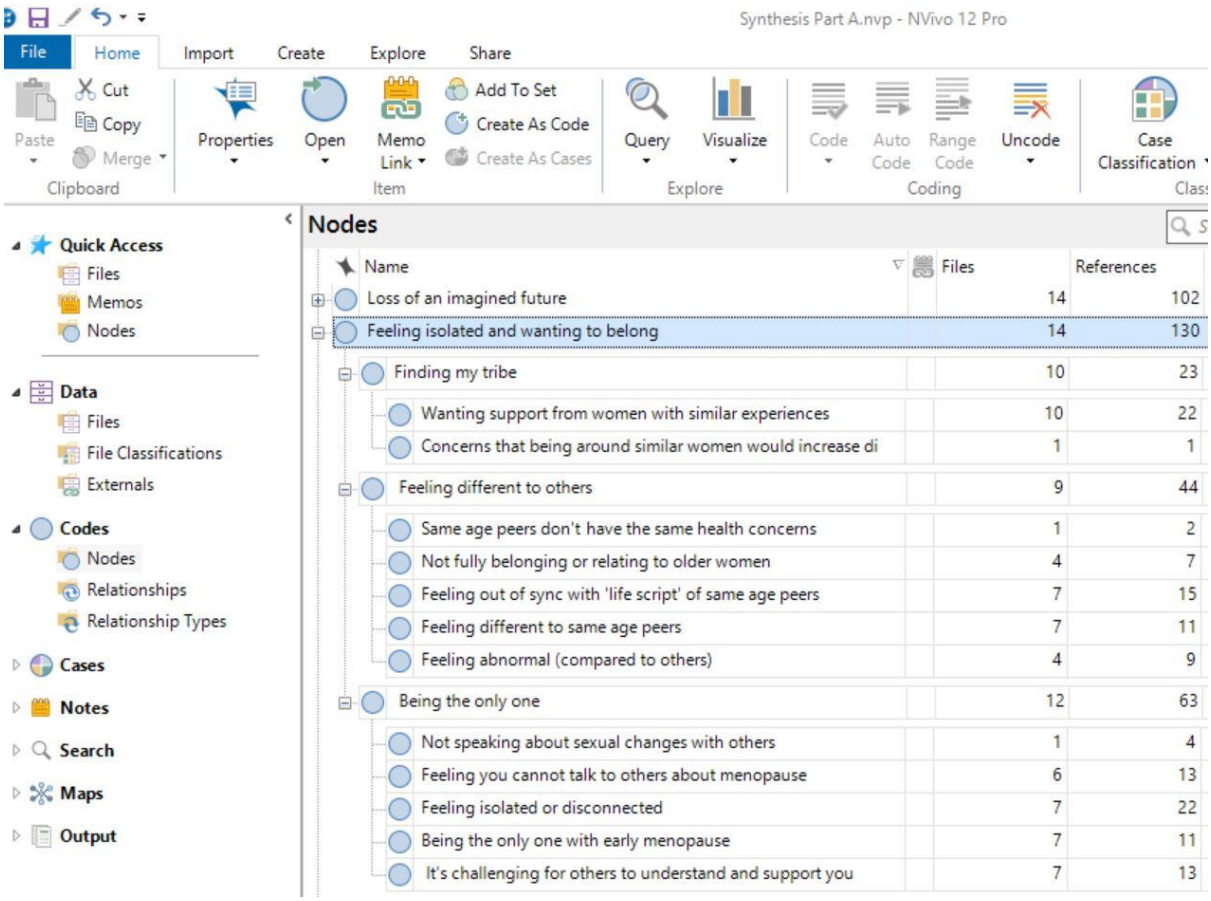


Extracts from the included studies (left-hand side, highlighted in yellow) were inputted into Nvivo. Relevant data was then 'coded', i.e. labelled with a code that described its content or meaning (right-hand side). Codes with coloured lines attached represent the codes applied to this extract. This process was completed across all included studies.





The coding process resulted in a bank of codes (a subsection on the left-hand side is provided above as an example). The number of studies (or 'files') that included extracts labelled with a code and the total number of extracts (or 'references') labelled with that code is shown. In the highlighted example, 15 extracts across seven studies were labelled with the code 'feeling out of sync with same age peers'. Examples of coded extracts are also demonstrated on the right-hand side. This demonstrates 'translation', i.e. different extracts from different studies being identified as featuring a similar concept.



The final codes were grouped into subthemes and then grouped into analytical themes based on an overarching concept that addressed the review question. In the example above, five codes formed the subtheme ‘Being the only one’, five codes formed ‘Feeling different to others’, and two codes formed ‘Finding my tribe’. These three subthemes were grouped together under the overarching concept of ‘Feeling isolated and wanting to belong.’

Appendix C: Recruitment poster

Share your story

Doctoral study into Black women's experience of the menopause transition

Are you?

- A Black or mixed-ethnicity woman living in the UK
- Aged 46-60
- Whose final menstrual period was between **2016-2022**
- Whose menopause occurred naturally

Why take part?

There is limited research looking into how Black women in the UK experience their transition to menopause. Taking part in this study would help us understand more about the needs of Black women during this life stage.

What would taking part involve?

You will have a conversation with the researcher via videochat about your thoughts, feelings and experiences as you approached menopause. **You will receive a £20 gift voucher as a token of appreciation for your time. All personal data will be kept confidential.**

For more information or to take part, please email the researcher, Thema Peart.

TP247@CANTERBURY.AC.UK

This study has been approved by the Salomons Institute for Applied Psychology Ethics Committee

Canterbury Christ Church University

Appendix D: Participant information sheet

Salomons Institute for Applied Psychology
1 Meadow Road, Tunbridge Wells, Kent, TN1
www.canterbury.ac.uk/appliedpsychology

Participant Information sheet

Ethics approval number: ETH2122-0113
Version number: V4

Lead researcher: Thema Peart

An exploration of Black women's experience of natural menopause transition.

You have been invited to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you. If you are happy to participate, you will be asked to complete a consent form.

What is the research about?
The transition to menopause is a life stage that all women go through. Despite this, the transition to menopause is a unique experience for each woman. Evidence suggests that women from different ethnic groups may have different physical and emotional experiences as they go through the menopause. They may have different thoughts and feelings about this change, what it means to them, and respond and seek help differently. However, most of what we know about women's experience of the menopause transition comes from White British women's accounts. There is a risk that health professionals do not understand or recognise the specific needs of Black women during the menopause transition.

The purpose of this research is to find out more about Black women's perspectives and experiences of their menopause transition. The hope is that this will lead to a more comprehensive understanding of how women of all backgrounds experience this period of their lives. This may support healthcare professionals to offer more culturally sensitive support and advice.

Who has reviewed the study?
This study has been reviewed and approved by The Salomons Institute for Applied Psychology Ethics Panel, Canterbury Christ Church University.

Why have I been invited to take part?
You have been invited because you are a Black woman living in the UK who has reached menopause. Therefore, you can give a perspective on the menopause transition that has not received much attention in previous research. However, it is your unique experience that is important. No one person can speak for an entire group, and your account will not be expected to represent all Black women. Other Black women will be invited to talk about their experiences.

To take part in this research, you must meet the following criteria:

- Identify as Black or mixed-ethnicity of African and/or Caribbean heritage.
- Aged 46-60
- Live in the UK
- Speak English
- Have had at least 12 months of no periods (i.e. have reached menopause).
- Your final menstrual period was between 2016-2022
- Lived in the UK for the 8 years leading up to your final menstrual period

Unfortunately, you will not be able to participate if you reached menopause before the age of 45, your menopause was triggered by medical intervention, or you were diagnosed with a significant **and** long-term health condition before you reached menopause, e.g., HIV or cancer. The perspectives of these women are equally important, and it is hoped that future research will explore their experiences.

Do I have to take part?
It is up to you to decide whether to join the study. If you agree to take part, you will be asked to sign a consent form. You can withdraw at any point before or during the interview without giving a reason.

Once your interview is completed, you can withdraw your interview data for up to two weeks. After this point, your interview would have been incorporated into the pool of responses from other participants and analysed; therefore, it would be difficult to extract your interview data.

What will I be asked to do if I take part?
I, the lead researcher (see picture on page 1), will contact you to arrange a convenient time for you to talk to me about your experiences. You will be interviewed **once** for approximately 60 minutes via an online videoconferencing platform (e.g. Zoom or Microsoft Teams). The interview will be recorded so it can be typed up and analysed.

We are interested in the thoughts and feelings you had as you approached menopause, how you made sense of this transition and its impact on you. As such, the interview will not solely focus on the physical 'symptoms' you experienced. The researcher will ask you questions to guide the interview; however, what you share is your choice.

Expenses and payments
All participants have the option of receiving a £20 Amazon voucher as a thank you for taking part. To receive the voucher, your e-mail address will be securely given to the University finance department who will issue the voucher after the interview. Your details will not be used for any other purpose.

What are the possible benefits and risks of taking part?
Talking about personal and/or sensitive topics can lead to distress. However, you will not have to talk about anything you do not want to. If you think it is likely that you will become significantly distressed during the interview, then we would advise you not to take part.

I cannot promise that the study will help you personally. However, the information we get from this study will hopefully help health professionals better understand the needs of future Black women entering menopause who live in the UK. You may find having the opportunity to discuss your experiences during the interview beneficial.

What if there is a problem?
Any complaints about how you have been treated during the study will be addressed. If you have a concern about any aspect of this study, you can contact the lead researcher at t.peart247@canterbury.ac.uk, or by leaving a message for **Thema Peart** on the 24-hour voicemail phone number [number].I will get back to you as soon as possible. If you remain dissatisfied and/or wish to complain formally, please contact the number above and ask for **Margie Callanan**, Programme Director.

Will information about me be kept confidential?

Yes. I will follow ethical and legal practice and all information collected from you will be kept strictly confidential. There are some rare situations in which information would have to be shared with others. Below is an explanation of what data is collected and what happens to it.

- Before the interview, the lead researcher will collect some demographic information.
- The interview will be recorded on a password protected device and written up.
- In the write up of the interview all identifiable information, e.g. your name, will be changed (pseudonymised).
- All data will be stored securely on a password protected and encrypted computer drive during the course of the study.
- Only Thema Peart and her supervisors (Dr Fergal Jones and Dr Myra Hunter) will have to access the audio recording of your interview and the pseudonymised write-up.

- The only time I would be obliged to pass information onto a third party would be if you disclosed something during the interview that made me concerned about your safety or the safety of someone else.
- Anonymous quotes from your interview may be used in publications about the research.
- Once the study is complete, the pseudonymised transcripts will be stored on a password protected and encrypted computer drive for 10 years in keeping with University research guidelines. After 10 years, they will be destroyed.
- For more information about data protection, please see the University's research privacy notice https://www.canterbury.ac.uk/university-solicitors-office/docs/research-privacy-notice.docx

What will happen to the results of the research study?

The final results will be written up into a report and may be published in a scientific journal. All information and quotes from your interview within this report will be pseudonymised (use a false name). Therefore, it should be not possible for someone to identify you.

Who is sponsoring and funding the research?

Salomons Institute for Applied Psychology at Canterbury Christ Church University is funding this research.

Further information and contact details

If you would like to speak to me and find out more about the study, please contact me at t.peart247@canterbury.ac.uk.

Appendix E: Consent and demographics online questionnaire

The online questionnaire was formatted so that participants had to give consent before being able to enter and submit their demographic information.

Consent form

Ethics approval number: ETH2122-0113

Version number: V4

1. I confirm that I have read and understand the information sheet dated July 2022 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I confirm that I meet the following eligibility criteria:

- Identify as Black or mixed-ethnicity of African and/or Caribbean heritage
- Aged 46-60
- Speak English
- Have had *at least 12 months* of no periods (i.e. confirmed menopause)
- Final menstrual period was between 2016-2022
- Did not have your final menstrual period before the age of 45
- Menopause was not triggered by a medical intervention e.g. chemotherapy
- Live in the UK
- Lived in the UK for the 8 years leading up to your final menstrual period
- Did not receive a diagnosis of a significant and long-term health condition during your menopause transition

3. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview and up to two weeks after the interview, without giving any reason.
4. I understand that data collected during the study may be looked at by the research supervisors [Dr Fergal Jones and Dr Myra Hunter]. I give permission for these individuals to have access to my data.
5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings.
6. I agree to my interview being audio/video recorded.
7. I agree for my anonymous data to be used in further research studies. [**This criterion is optional.** You do not have to consent to number 7 to participate.]

If you select 'Yes, I give my consent', then you are stating that you agree to the statements above and agree to participate in the study

If you do NOT consent to participate then please close the webpage. No other action is required.

Do you consent to participate?

◯ Yes-I give my consent to participate in the study including option 7
◯ Yes- I give my consent to participate in the study excluding number 7

Next

Demographics

Participants are required to answer questions 1-5 for the purpose of the study.

Q1: What is your age?

Q2. The language used to describe one's race/ethnicity is personal. Please tick the box that you feel best describes your racial/ethnic identity.

- ◯ Black African
- ◯ Black Caribbean
- ◯ Any other Black African or Caribbean background (please specify below)
- ◯ White and Black Caribbean
- ◯ White and Black African
- ◯ Any other Mixed/Multiple ethnic background which includes a parent from an African/Caribbean heritage (please specify below)

If you selected "Any other background' please use the space below to specify

Q3. In what year was your final menstrual period?

- ◯ 2016
- ◯ 2017
- ◯ 2018
- ◯ 2019
- ◯ 2020
- ◯ 2021
- ◯ 2022

Q4: In which country do you live?

- ◯ England
- ◯ Scotland
- ◯ Wales
- ◯ Northern Ireland

Q5: In which country were you born. Please write below.

Please click the **Next** button for Questions 6-11

Next

Questions 6 - 11 are optional. However, answering these questions would be helpful for understanding more about your individual circumstances and how these are similar or different to the other women being interviewed.

Q6: What was the highest level of education you completed?

- ◯ No formal qualifications
- ◯ Level 1: 1-4 GCSEs or Scottish Standard Grade or equivalent qualification
- ◯ Level 2: 5 or more GCSEs/Scottish Higher/ Scottish Advanced Higher or equivalent qualifications
- ◯ Apprenticeship: Apprenticeships (England /Wales/Northern Ireland only)
- ◯ Level 3: 2 or more A-levels/ HNC/HND/ SVQ level 4 or equivalent qualification
- ◯ Level 4 or above: First or higher degree/professional qualifications or other equivalent higher education qualifications
- ◯ Other qualifications: Other vocational / work related qualifications and non-UK / foreign qualifications

Q7: If you are currently working please state your current occupation.

Q8: What is your marital status?

- ◯ Single
- ◯ Cohabiting
- ◯ Married
- ◯ Divorced
- ◯ Widowed

Q9: Do you have children?

- ◯ Yes
- ◯ No

Q10: Are they your biological child(ren), adopted child(ren), or both?

- ◯ Biological
- ◯ Adopted
- ◯ Both
- ◯ N/A

Q11: Are you currently using, or have you ever used, hormone replacement therapy (HRT)?

- ◯ Yes
- ◯ No

Please click NEXT to submit your answers. Thank you for your time. The researcher will be in contact shortly to arrange your interview.

Next

Appendix F: Interview schedule

Setting the context

- Thank interviewee for their time
- Introduce self, brief overview of research and reiterate the purpose
- Confirm understanding of information sheet and confirm consent
- Opportunity to ask questions
- Explain the nature of the interview, e.g., duration, use of schedule and prompts, stress that there are no right or wrong answers, that it is a mostly one-sided conversation, don't need to answer questions/can stop interview
- Clarify use of language, e.g. menopause, perimenopause, postmenopause**.**

Engagement and opening questions:

- What made you decide to participate in this study?

- Take date of FMP and ask them to estimate how long their perimenopause lasted, i.e context for interview

	Main question	Possible prompts/questions
1	Please could you do your best to remember back to before you started experiencing signs of perimenopause. Could you tell me what your expectations of the menopause transition were at that time?	What ideas/impressions/expectations? Concerns/positives?
2.	Where do you think your ideas and expectations came from?	What had friends and family said about the menopause? Did you have any impressions or expectations based on how other women in your immediate circle had experienced their perimenopause? What had you heard/seen in the media? Do you feel being a Black woman influenced how you felt/responded to narratives of menopause in society/the media in any way or not? If so, how?

		Did you have any expectations of becoming menopausal that specifically related to you being a Black woman? Or perhaps this did not seem relevant?
3.	Now, try and come forward in time to when you first started experiencing signs you were perimenopausal. I'd like you to talk about your experiences during this time and what it was like for you.	What made you think you were perimenopausal? What signs did you experience? Did your experience match your expectations? Can you tell me what you were experiencing physically, emotionally, your wellbeing? How did you feel about what was happening? What words would you use to describe it? What impact was this having on your life at that time, if any? -Work, relationships, family body image, Were there areas it impacted more? Less?
4.	As your perimenopause continued, how did things develop from there?	Can you tell me what you were experiencing physically, emotionally, your wellbeing? Did your thoughts and feelings about it change? If so, how? What impact was this having on your life at that time if any? -Work, relationships, family body image.
5.	Do you feel the menopause transition changed how you viewed yourself at all, or not?	If yes, how? -In relation to gender/being female? -In relation to ethnicity? -Any other areas?

		If no, what remained the same? Why do you feel this was the case? What supported that? Do you feel your menopause transition offered any opportunities for personal growth or change? Do you feel it impacted how others related to you or not? Did you make any individual/personal changes, e.g. diet, exercise, spirituality or not?
6.	If you sought support for issues relating to your menopause, what were your experiences of seeking this support?	If help was sought- Whom did you go to? How did you come to that decision? How was your request received? What did you hope would happen/How did you anticipate it would help? What was the impact (if any)? If not- Explore why. What influenced your decision to not seek help? Do you feel being a Black woman influenced how you did/did not seek help, or not? Can you tell me what, if anything, you found supportive/helpful or unsupportive/unhelpful as you went through this transition? What information/help might you have wanted?
7.	*Synthesising/clarifying question* What are your perspectives on how being a Black woman influenced your experience of the transition, if this felt relevant or feels relevant now?	Do you feel this influenced anything on a personal level? E.g. your thoughts, feelings about your menopause transition. The actions you took/didn't take? Did it influence your interactions with others at all?

9.	Is there anything else about your experience of the menopause transition that you feel is important to say?	Were there any other cultural influences you think were important for your experience of the transition? Other influences?
10.	Could you tell me how your life is now, postmenopause?	Are there elements of the experience you just described that are still ongoing?

Appendix G: Ethics approval

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Appendix H: Written debrief information

Salomons Institute for Applied Psychology
1 Meadow Road, Tunbridge Wells, Kent
TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Participant Debrief Sheet

Ethics approval number: ETH2122-0113
Version number: V2
Date: June 2022

An exploration of Black women's experience of natural menopause transition.
Thank you for taking part in this research; your time and effort is much appreciated. Below is some important information to be aware of now that your interview has taken place.

What will happen now?
Your interview will be typed up, and all identifiable information changed (e.g. names, job titles). Your interview data will be pooled with other interviews collected during the study and key themes identified which categorise the similarities and differences between the participants' experiences.

All participants have the option of receiving a £20 voucher as a thank you for taking part. Please contact the lead researcher at t.peart247@canterbury.ac.uk to receive this.

Who will have access to my data?

Only the lead researcher and her supervisors (Dr Fergal Jones and Dr Myra Hunter) will have access to your interview and demographic data. The only time your information would be passed onto a third party is if you disclosed something during your interview that indicated that your safety or the safety of someone else was in jeopardy.
Please refer back to your Information sheet for more detailed information on confidentiality and data protection.

I wish to withdraw my interview from the study. What should I do?
Please contact the lead researcher on t.peart247@canterbury.ac.uk within **14 days** from the date of your interview. After this point, analysis of your interview data would have begun. You do not need to give a reason why you wish to withdraw. The lead researcher will confirm receipt of your email, and your interview and demographic data will be deleted.

Whom should I contact if I have a concern or complaint?
You can contact the lead researcher at t.peart247@canterbury.ac.uk, or by leaving a message for **Thema Peart** on the Salomons Institute 24-hour voicemail at [number].I will get back to you as soon as possible and do my best to address your concerns. If you remain dissatisfied or wish to complain

formally, please contact the number above and ask for **Margie Callanan**, Programme Director. Alternatively, you can email at Margie.callanan@canterbury.ac.uk .

Will I receive feedback on the findings?
If you would like to receive a brief report outlining the study's final findings, please contact me at t.peart247@canterbury.ac.uk. This report will be available once the study has been completed at the end of 2023 at the earliest. Please note that the feedback will be anonymised and represent the experiences across the participant group as a whole.

I would like further support. Where could I find this?

Mental/Emotional support
If you feel you would benefit from talking therapy or other forms of support, then please make an appointment with your GP to discuss this. If you live in England and wish to access talking therapy, you can contact your local NHS Improving Access to Psychological Therapies (IAPT) service. You can search for your local IAPT service by visiting https://www.nhs.uk/service-search/other-services/.

If you wish to seek private therapy, it is advised to seek a therapist who is **registered with a professional body**. Further information about this can be found here https://www.mind.org.uk/information-support/drugs-and-treatments/talking-therapy-and-counselling/how-to-find-a-therapist/

If you wish to speak with a private therapist from a Black background, you may wish to search for a registered therapist on the Black, African and Asian Therapy Network at https://www.baatn.org.uk/

Accessing menopause support and information

For general medical advice regarding menopause, you can visit https://www.nhs.uk/conditions/menopause/ or speak with your GP.

There is a range of information and advice regarding menopause online. However, the accuracy and quality vary. Below are examples of websites that provide independent information and guidance; however, these are not recommendations or confirmation of the validity of the information provided.

Women's Health Concern: https://www.womens-health-concern.org/ . They are the patient arm of the British Menopause Society.

Menopause matters: https://www.menopausematters.co.uk/

Thank you for your participation.

Appendix I: Abridged reflexive journal

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Appendix J: Annotated transcript (Part B)

This has been removed from the electronic copy.

Appendix K: Theme development table (Part B)

Theme	Subthemes	Codes	Example quotes
Starting a journey with an incomplete map	A shroud of silence around menopause	Lack of discussion means you lack knowledge	"if we were taught in school about perimenopause and the menopause then I would have put two and two together but because you're not told about that, you just don't know"(Joss) "I think because there wasn't that , you know [pause] Openness about menopause within the women of our family, with our aunties, uncles or anybody like that then you can it can become 1. A taboo subject 2. You get misinformation and 3. You're left ignorant and it just comes upon you and you don't really know what's kind of happening" (Carol)
		Menopause was not openly discussed in society	"I still think it's just one of those sort of taboo subjects" (Amaka) "there wasn't a lot in the media." (Sade) there weren't really that many books on menopause so it wasn't really a subject that was discussed in public" (Beverley) "It just is not discussed, just not discussed" (Dee)
		Menopause was not openly discussed amongst friends	"because none of my, you know, none of my family or friends mentioned at all, you know, that they had, well, you know, had or were experiencing a similar things that I was experiencing" (Joss) "I suppose all those around me, like my friends and my sisters, didn't really discuss it" (Beverley)
		Menopause was not openly discussed within family	"Aunties that I was close to growing up never mentioned any menopause" (Femi) "my mum didn't talk about it and no one else that I knew talked about it so it's generally a no-go area" (Danai) "My mum as I said didn't really talk about it, my sister didn't talk about it even, you know, as we got older. There was no conversation really about, you know, the menopause and what to expect and how it could have all these different elements to your health and and things like that. It just wasn't talked about, the conversation." (Brianna)

	Limited expectations and forethought	Unaware of perimenopause stage	"So I thought menopause would suddenly come and the period would stop. So I didn't think there was something called perimenopause" (Femi) "I just assumed you become when you get old, and I think what I probably meant by that was in your 70s, you don't have periods and that was the end of it."(Dee) "I didn't realise there is actually a build up to it. I didn't realise there was a perimenopausal stage. None of that." (Mindy)
		Expected hot flushes	"So I knew hot flush. I knew that my period would stop." (Carol) "that was like the main symptom that people talked about was the hot flashes. And so, yeah, I knew the hot flashes were gonna happen." (Beverley)
		Expected mood changes	"I don't think I had many expectations other than um mood. Change in mood." (Brianna) "I didn't really know much about what the menopause or perimenopause was um obviously your period stop and um you get hot flushes and that's it. And maybe a few mood swings." (Joss)
		Having few expectations	"I would say that my expectations of perimenopause were very, very little." (Amaka) "I didn't think I had any expectations" (Femi) "I really didn't have any expectations because it really wasn't talked about." (Sade)
		Minimal knowledge of MT effects on the body	"I didn't actually think that there was gonna be anything else going on with my body. I thought my periods would stop. I heard about the hot flushes and that was it" (Carol) "I didn't realise there was a *whole thing* around it because if I'd know there's whole thing around it then maybe I would have done a bit more trying to find out a bit more or whatever. (Mindy)
		Expected menopause transition to be manageable	"thought that I would sail through. I thought that I would be able to manage it and it wouldn't be a problem for me because I felt that as long as I was able to be on top of it and deal with things as it

			came along then I would be able to cope." (Carol) "it didn't seem like anything that I needed to be really concerned about. " (Brianna)
		Expected an easy transition due to impression from previous generations	"And so once I started experiencing symptoms, I just expected it to just go quite smoothly because my mum's wasn't problematic to her" (Dee) "I guess because I assumed my mum went through it and she never mentioned it to us, she had three daughters, and didn't say anything and I know she doesn't have periods so I just assumed that it's an easy transition." (Danai)
		Did not think about menopause ahead of time	"I'm just saying it happened in my mid 50s and I thought that, you know, that would have been a good thing to have discussed or for me to have gone away and done a bit of research on that if I'd thought about that but my head at the time wasn't thinking about the menopause." (Amaka) "It wasn't on my radar, it was a bit of a shock" (Dee) "But at the time, you just think, you always, you know it's coming whether you really think about it, and you're not really thinking about it as such." (Mindy)
A varied experience	Changes attributed to menopause	Psychological changes	"I'm quite a calm kind of person and I just couldn't be putting up with people's nonsense. Yeah. I just felt that I was a bit, a bit shorter. Not foul tempered, but just a bit short." (Brianna) "I suppose the shortness of temper as well, not being as patient. I didn't realise that until it was pointed out to me." (Beverley)" "Just in a bad mood. Really just irritated and less patient." (Dee)
		Somatic/physiological changes	"I can still, I still get like hot flushes so therefore it's still around, I'm very conscious of it." (Carol)

			"I'm in the menopause, the weight is not shifting at all. Previously it would shift, but now whatever I'm doing diet, exercise the weight is not shifting at all." (Joss) "It was mainly at nighttime when I was just hot and cold, not sleeping well and really, really broken nights." (Amaka)
		Changes attributed to perimenopause retrospectively	"I was able to relate so many more things to menopause because of the group." (Carol) "So it's the increased heat and then with my skin that felt quite itchy as well and it wasn't until years later that I realised that was part of the menopause, because I didn't realize that was part of perimenopause." (Beverley)
		Attributed potential menopause transition changes to other causes	"I didn't relate it to menopause at all and I understood it as being stressed" (Dee) "So and at the time, probably if I didn't have him [baby] I might have been more tuned to what was going on symptom wise and stuff like that. But when you've got a young baby you expect to feel tired, you expect to feel a lot of the stuff so it was probably masked for me." (Mindy)
	A variation of responses	Embarrassment about sweating	"If was to go out for a meal with friends or my partner just, you know, sitting in a restaurant, just beads of sweat just, again the embarrassment of the physical signs of it." (Joss) "I thought they were quite embarrassing because they were, they were very obvious, if it happened in the workplace it's very obvious to people around you and sometimes we're sat in the meeting and you're suddenly just …uh…you feel so warm." (Mindy)
		Positive feelings about end of menstruation	"I was elated! I was thinking Oh God right I don't have to buy sanitary bits. I was thinking oh that is coming to an end." (Sade) "For me it was good, I don't have to do anything, yes! I can be free, you know. You can, have a relationship, you know, me and my husband can, not have to worry about what I have to take or what he needs to do." (Danai) "I really celebrated when my period stopped" (Beverley)

		End of fertility felt like an ending	"I can't have anymore children. So that's the end of, not the sex, but end of childbirth. So that's kind of like, closure to that thing which is a bit hard." (Danai) "There's a transition from, you know, being able to, I suppose, have periods and know that I could nurture a child and that has now come to an end, you know is coming to an end, you know, yeah, I found that devastating for me really. Sort of like a final chapter in that particular area of, you know, of my life." (Brianna)
		Annoyance	"Yes, at times when it [period] came, I was actually quite frustrated and angry. And like, you know, I thought you'd gone. Why are you here now? (Femi) "I'd just be really annoyed more than anything else, just like, oh, my God, I can't believe I've woken up again." (Mindy)
		Sadness	"I think the sad part about all of that is that on a sexual side your libido goes right down, so then your sexual drive goes down. And I was like, I was quite disappointed about that." (Carol) "Just feeling that things are changing and having to accept that and looking in the mirror and you know having to cut my hair really short, not wanting to wear weave or a wig or anything like that. You know, I've sort of made decisions about that in my life and that was really quite, quite saddening for me." (Amaka)
		Feeling less attractive	"My hair was thinning which was also partly attributed to [redacted] but also it is also attributed to the perimenopausal stage as well and so just kind of feeling sort of less, less womanly, less attractive (Amaka) "I think I felt um, quite unattractive. I think invisible as well" (Mindy)
		Feeling surprised by physical changes	"And you know this this weight gain and massive boobs but it's just, I don't, I don't like it. It feels shocking. It feels like it's been quite sudden" (Dee) "That was a real shock to my system and you know, and not having orgasms. They weren't as strong as they were when I was much younger and I never thought that it was gonna be, I never thought that it would be like that." (Carol).

		Feeling you have less control over your body	"I said, you know, initially feeling a little bit sort of down about what I was going through and not not feeling that I was able to take control of that." (Amaka) And then the weight not shifting. It gets me down sometimes because I'm exercising, I'm dieting, I'm eating the right things and it's just whatever I'm doing it's just not moving." (Joss) "I think the first few times it [hot flushes] happened, I was really ohh my god! You know, why is this happening? Why is it happening right now when I can't really do anything about it." (Mindy)
	The intensity of changes influences the experience	Experienced minimal changes	"So even then I was, people were denying me like 'Nah you're not going through the menopause, you're not experiencing anything that I'm experiencing. You're not even having any night sweats." (Danai) "I suppose I'm quite lucky in a way, because I know there's, how many symptoms of the menopause? It's quite a few. I'm lucky that I'm only having two or three of them. (Joss) "I can just remember about feeling quite warm, but it was only at night. It was only at night. Not in the day. And I was able to cope and then it wasn't every night, it was it was quite sporadic." (Carol)
		Changes were gradual	"It's been a slow transition for me" (Sade) "But it was all very gradual. You didn't just wake up all of a sudden and everything kind of hit you all in one go, and I think I'm really kind of grateful for that" (Carol)
		Experienced minimal disruption	"Apart from the sweating and hot flushes, it didn't have any sort of effect on me. Basically if I wasn't having those symptoms, I wouldn't have known" (Joss) "I just went through it so it didn't, it didn't really affect me in any way that made me think ohh my gosh, I need to go and see the GP, I need to, you know, do anything about it really in that sense" (Brianna) "I was having hot flashes but not hot flashes that were causing me any kind of distress or concern, you know" (Beverley)
		Significant changes meant significant impact	"It's been, it's unpleasant. And I don't like it. The emotional side of losing hormones has been a massive, has had a massive impact on me and what I am." (Dee)

	Am I experiencing something different as a Black woman?	Black women's experiences may be different to others	"And it's said that we do go through the menopause differently to our white counterparts." (Sade) "But I would also have loved to have a support group for Black women that talk about these things and kind of peculiarities to kind of Black women or.. I don't know. (Femi)
		Black women need tailored support	"I think as a black woman and from my perspective I think there need to be some tailored support out there for women of colour because we do, we voice things differently and we are more vocal in certain areas, and I think because probably our upbringing is very different to our white counterparts and our other ethnicities." (Sade) "I would have loved to have a group of women talking about, especially Black women, about what we were all experiencing." (Femi)
Reaching a landmark of ageing	Becoming aware of ageing	Awareness of an expectation of act 'older'	"For me I thought I'd have to dress differently and maybe not wear leggings and the T-shirts and stuff like that. I'd have to wear them frumpy dresses and a big hat and stuff like that" (Danai) "I think sometimes when you get to a certain age, you almost think you have to change because society tells you." (Beverley)
		Menopause means getting or being 'older'	"I felt too young to be doing something that old women did, yeah? Cause I was still sexually active and still interested in, I was still going out and doing things, I didn't feel old, so it was, there was a resistance to it." (Dee) "I think it's something to do with…because menopause is a recognition of an ageing stage, a stage of aging, isn't it?" (Mindy)
		Ageing means ill health and decline	"Because I've seen how many others, individuals saying 'oh after my menopause everything went downhill". (Danai) "Just becoming really ill and not wanting to go outside and you know or not wanting to go outside but, you know, like not venturing out so much because you've got these aches and pains." (Brianna)
		Ageing means losing your attractiveness	"But I guess it's also how the media portrayed it all during the course of my lifespan and prior to that. Menopause is

			you're getting old, you're on the shelf, you don't look attractive" (Danai) "We live in a society where you don't wanna age, you know. Beauty's kind of revered for women. " (Dee)
		Being older means you're no longer of value or use	"So it's taboo around the menopause like ohh you should be seen not heard" (Danai) "Because I think at that time, and probably I still hold a bit of this thought, that with aging you're written off. It's the end of something." (Dee)
	Resisting or adopting the ageing narrative	Feeling a loss of youthfulness	"I think the tinge of sadness is that you are not that young vibrant person anymore are ya?" (Sade) "Well, loss, I suppose you know, that feeling of sort of loss of youth [pause] Yeah, feeling sad about it" (Amaka) And also just how losing the estrogen feels as if [laughs] it's funny. It feels if your face is kind of falling down, you know, like, I feel old. (Dee)
		Not wanting to be categorised as old	"It was a bit like a resistance to it of I don't want to age" (Dee) "You just don't wanna be classified like people will say, oh, use your walking, walking stick" (Danai)
		Resisting societal narratives	"And I just sort of think no, I'm getting younger. I'm getting younger ….I say because I'm getting younger because I feel that if you start labelling yourself it's like a self-fulfilling prophecy" Brianna) "I wasn't gonna be this grey woman in a, you know, that couldn't walk properly or struggle to get up or was always complaining about something or dressed a particular way." (Beverley) "I just feel like a lot of us forget to life in a manner, so that when we get to retirement we just thing retirement means stopping. So when I get to retirement I don't want to stop, I want to carry on doing something" (Sade)
	A turning point into healthy ageing	Making healthy lifestyle changes	"I go swimming everyday. That's part of managing this." (Femi) "I look out for healthy recipes, try cooking healthy foods and trying different kinds of foods. I go out, I exercise every day. I keep myself active." (Joss)

			"But it's made me a lot more conscious about my body and how to look after it, where as I was conscious about it before, but not in terms of the fact that I'm going through menopause." (Carol) "I've changed my eating, I stopped eating meat about seven years ago you know I decided to make a conscious effort to focus on my health." (Brianna)
		Looking after physical health is important	"My body is a temple, I have one body and I have to look after it as best I can" (Carol) "It's freed up that sort of oh yeah the young vibrancy , you don't need to be young and vibrant to still carry on doing what you need to do, you just have to look after yourself well and do the research around looking after yourself well." (Sade)
		Looking after health to avoid ill health and decline	"I want to live long so I know I have to eat healthy " (Femi) 'So just living my life as healthily and actively as I can to help me in later years, so I maybe don't have conditions that can debilitate you as you get older" (Joss) "I think it is also about, well it's not about not wanting to get old but trying to maintain my youthfulness for as long as I can." (Brianna)
	Making the most of my time left	Engaging in new activities	"Just experiencing things out of your comfort zone and just doing different things" (Sade) "I came to a point where I just thought I'm gonna do things now because I really felt that in my younger years that I prevented myself from stepping out and trying different things" (Brianna)
		Wanting to make the most of life	"I think maybe it is because you think, OK, this is the the last-ish chapter. You know, when my children are getting older and I'm still an able-bodied person, luckily, touchwood this is that time of, you know, much enjoyment" (Amaka) I haven't done anything, I've sat back and let life pass me by without doing certain things and it's like I don't want that. I want to enjoy everything now and keep doing it so that when I get to retirement I've embodied loads" (Sade)

		Prioritising myself	I tended to put other people first a lot more than myself so its like the last few years now it's being like my self- care needs to be the first person who to actually sort of benefit from it. (Sade)
Adjusting and Carrying on	Carrying on	Being too busy to pay attention to changes	"I was kind of going up my career ladder, being promoted and focused more on work…So what was happening with my body was kind of like a secondary attention (Femi) "And when you're working, you're not paying attention so much to your body." (Carol) "You're just trying to live basically and trying to get on with stuff so you don't [pause] you're just trying to keep your head of the water, you know. You don't have time to really analyse it." (Mindy)
		Did not go to GP as changes were not significant	"I wasn't kind of bothered about it so I didn't go to the doctors or anything to check what was going on. I just kind of went with it." (Femi) "but there's so much going on, you know, it's it's not something I would have gone to the doctor about." (Mindy)
		Getting on day to day	"I think I just put up with it" (Amaka) "I don't understand what's going on, but let's just, let's just go through it." (Femi) "I had to go to work, so I didn't have the option of staying at home. I just had to get out there and get on with my life and deal with the hot flushes as and when they came." (Joss)
	Mental adjustment	Accepting changes as part of life	"I'm kind of just open and go with the flow because if you can't change it or stop it then you have to go with it so that's how I choose or chose to just do it." (Brianna) "It's a natural progression and we need to be able to identify that it's nothing wrong with us and I think that helped." (Danai) "I think it's just for me I think it's just part of life. Something you have to go through in life." (Femi)
		Resilience	"I don't know if that's my upbringing in Africa, you know, be a tough cookie and say yes life is a battlefield anyway you

			just have to go through it and make sure you make the best of it." (Femi)
		Reframing thoughts about vasomotor symptoms	"The first couple of times I was self-conscious and I thought people are staring at me and would talk about me and think I'm a strange sort of person, …and then now when it happens I just think, well, I'm in the menopause, there are thousands of women, you know, who are probably going through the same thing as me" (Joss) "So rather than think ohh this is horrendous, I almost turned it as something that I could kind of think well actually that's quite a nice feeling." (Beverley)
		Trying to maintain a neutral-positive mindset	"it's not necessarily a bad thing. It's a it's it's a positive, wonderful thing if you embrace it" (Amaka)" "I think positively the outlook that I have taken for me is about being as happy in yourself as you can be." (Sade) "I didn't want to, yeah, umm I suppose, predict that I would be this kind of way or that kind of way.I was just open." (Brianna)
		Not allowing myself to be limited by menopause	"The symptoms weren't going to affect what I did on a daily life on a daily basis so I suppose I had a different outlook." (Beverley) "At the end of the day you don't wanna sit back and be like it's the menopause it's killing me. Yes that's not me." (Sade)
	Perceived impact of racism on adjustment	Seen as an "Angry black woman"	"when it comes down to women of colour I think we are perceived as being quite aggressive and it's that thing where nobody is putting the actual two together, that it's the menopause, low mood, is this some anxiety or depression, what else is going on? They are not putting all that together and linking it they are just saying 'Oh there, that's an angry black woman' that's it. Nothing more." (Sade)
		Feeling more affected by racism	"When you speak, you're not heard or you're seen as uppity or aggressive. I've seen it. I've actually had that experience whereas I think when I was younger, I was able to do something else with that. I think I had a different tolerance and but now it's like I'm not having it." (Dee)

		Racism as an additional stressor	“It feels like another heavy thing to hold in my middle age, you know?” (Dee)
Seeking information and support	Informing myself	Doing my own research	“The little that I gathered was through talking to this homeopath and then also doing my own online research” (Amaka) “I read one or two things for me to be self aware of what could be going on” (Femi) “just sort of thought ok this is what's happening, let me do a bit of research let me see how I can support myself” (Brianna) “I would say after then, I started to just book after book after book after book. I then started really reading into it, really researching as well.” (Beverley)
		Information means you can advocate for yourself	“I made sure that I did my research before I picked up the phone and spoke to my GP because when I did that call, I was really clear as to what it was I wanted.” (Amaka) “ It's just that thing of when you go to the doctor, you really need to have an idea of your symptoms and be really confident of your symptoms, to be heard. You really do. And you need to know what products are out there as well, to be heard.” (Beverley)
		Valuing choice around information acquirement	“I was able to relate so many more things to menopause because of the group and because of, you know, women going through different things that they would post information for you to be able to go away and read. And I quite like that. Nothing's forced upon you” (Carol) “I will jump from one group to another, certain things that they'll say I think, well, I’ll take that bit and I'm not sure about that bit but I'll take this bit because I feel that could sit and work with me.” (Beverley) “you can do that in your own time you know, you can do that when you can, when you've got the time to do it and you're not necessarily sitting in a room and feeling that I, I can't I can't put my hand up, but it's all there for you.” (Amaka)

		Gaining knowledge from menopause groups	"But it's it's really the knowledge that I have about the menopause is, I would say, it's from these groups that I've been attending. It's not from going to my GP." (Mindy) "My menopause group has been like a lifeline for me in terms of the information that I've been able to glean from what we have done and what I've learnt." (Carol) "A lot of the support that you get is things that you can do to help your wellbeing. Exercise, diet. We've had one or two people come in that know more about these things". (Femi)
		Online information can be misleading	"I mean there's a lot of it there's lots of it and there are lots of people saying they are experts" (Sade) "I would say the information that can be unhelpful is more accessible." (Beverley)
	Menopause as a shared experience	Sharing with peers once transition started	"Now I can share because you know, my group of friends that are my age we're going, we're of that age and we're going through the same thing." (Joss) "But I would say that once we were in the perimenopause, that's when we've been talking about it but leading up to it, not at all." (Amaka)
		Groups offer emotional support	"But hearing other women's experiences and understanding what they're going through it, it helps a lot. It really does help." (Joss) "Just to get those feelings out and have them heard and, you know, people aren't gonna, they're not solving your, no one's there to solve anyone's problems or anything, but it certainly helps to feel listened to" (Mindy)
		Learning from other women	"I've learned to cope the best way I knew how to cope, but having a place or having a group where we can all share our experiences to say ohh, is there anything you do differently? You know, just learning from other women." (Femi) "It does help because you are sort of talking and you are sharing ideas" (Sade) "You also hear about things that other people are trying, have tried, how it's affected them, if it's any good ,you know?

			And so it's it's a very valuable source of info, you always get something out of it." (Mindy)
		I'm not the only one	With so many of us, you know. Yeah, I'm not alone. People are going through this, you know, just coping the best way they know how to cope. And I'm not alone, it just gives me a lot of reassurance. Just helps me to cope better knowing that."(Femi) "it's nice to know that you're not the only one, you know, going through it and some of the things that you're going through other people are going through." (Joss) "The impetus to join it [a group] was about trying to find out more about menopause and see what other people are going through, because sometimes you do sort of, it can be quite isolating." (Mindy)
		Not feeling understood in a majority White space	"I don't really wanna go back now just because I am the only black woman there[redacted], I'm already thinking but I don't, I don't know what you're about. You might. You might not understand that, you know." (Dee)
Picking a path: Hormone therapy or 'going natural'	Taking the natural path	Concerns about side effects	"When I looked into the medication, I didn't think it was for me because of the side effects." (Femi)
		Not wanting to interfere with the body	"I always just kind of think allow the body to fight any kind of disease that you have or just allow things to work its way through your system. So HRT never even occurred to me." (Carol) "if I'm gonna have to put stuff in my body I really need to know what I'm putting in" (Sade)
		My elders coped without it	"I'm a great believer of previous generation went through it. They survived, I should survive." (Femi) "I thought right how did our parents in the Caribbean and our grandparents manage? And like my grandma died at 106 without any sort of support and she had all her faculties." (Sade)
		Not needing hormone therapy due to mild changes	"I'm not having sleepless nights, I'm not, I don't need HRT, I don't need anything like that." (Brianna)
		Not liking medication	"I've always been quite wary about medication" (Femi) "I've always been quite averse to pharmaceutical drugs anyway." (Carol)

			"Even stay away from paracetamol where possible, because I just don't… I'll go to my bed or, you know, work it through." (Brianna)
	Changing route from natural to hormone therapy (HT)	Initial intention to not use HT	"I remember feeling at the time that there's no way I'm going on HRT, I'm going to try and do things naturally." (Amaka) "I was, you know, wanted to try and ride it out and all the rest of it and try and go like a natural route." (Mindy) "I didn't intend to go on HRT" (Beverley)
		Considered HT due to discussions in media	"I was heavily influenced by, I would say, the things in the media...." (Mindy) "Meg Matthews. She was talking about the menopause and I was very interested in what she had to say. And then from her there was a Doctor who was Louise Newson and she was on platform with her so I listened to what this woman had to say." (Amaka)
		Considered HT after hearing others accounts	"Having seen other people sort of, I suppose, really sort of say how HRT has helped them I thought I'm gonna give it a go." (Mindy) "I went to my GP and the doctor surgery and then I met my friend and she was, I suppose, she was so animated about the effect on her! And I kind of thought, I want some of that because she was **so** full of energy." (Beverley)
		Natural methods weren't effective	"I have tried some of these, uh, natural supplements that in terms of getting you know, getting a change to help me, it didn't come fast enough." (Amaka) "I suppose the natural remedies that I tried didn't work." (Beverley)
		Wanting to improve quality of life	"I was so tired and that nights were so bad and I was trying to get up to go to work that I needed to do something and that's when I decided to try HRT." (Amaka) "I though it would just get me back to who I who I was. Just kind of getting back on with my life and just getting to sleep when I wanted to sleep, going out, not feeling tired." (Dee)
		Making a different choice to peers	"I have friends that really believe that if you take HRT, that it's almost as though there's a weakness within you that you have to take this medication." (Beverley)

			"I suppose with some of my black female friends that they, a lot of them are just doing it naturally and so I kind of felt God, I'm really going against the grain of their beliefs, you know?" (Amaka) "So I was happy, I was happy to try it and remember, you know, friends would say 'oh I would never touch that. It gives you cancer" (Dee)
	Concerns about racial discrimination in healthcare	Black women are not cared for in the healthcare system	"I do feel that Black women's health in Britain you know we're not we're not looked after." (Amaka) "I feel like I should be more appreciative of the fact that I can get HRT because I know there's other women that can't, but I'm also conscious of the injustices that happened to black women, historically and even now." (Dee)
		Feeling health professionals may judge me negatively	"I don't want to go in and feel insecure or feel judged that -oh she doesn't know what she's talking about and what would one expect from her anyway? And I mean that as being a black woman." (Amaka) "So I'm frightened now of my GP… I'm just like do they say 'Oh it's Dee. That angry woman' you know? So you come with a story and there's an assumption. (Dee)"
A period of growth		Being my authentic self	"I actually feel more free, if that makes sense. I feel like I'm not restricted." (Danai) "I used to straighten my hair so my hair was very straight, very chemicals. And if I didn't straighten my hair, I then had plaits that were extensions and I would have long extension. But for me, as a black woman, that actually isn't who I am. So, yeah, I almost feel then I was in chains, but now I feel like those chains have been ripped off, and this is who I am" (Beverley) "And then as I came through the menopause, going through the menopause, I sort of thought I need to be myself." (Brianna)
		Being more vocal	"I'm not worried about what I say now either. Not not worried about what I'm saying, that's a bit rude, but if I feel something is wrong I feel quite confident to speak up and say something." (Danai) "I'm actually speaking out whereas before, I wouldn't say anything." (Joss)

			"I will positively challenge certain things where before I probably would have just thought, oh, no, it's more about them than it is about me and just let it slide." (Beverley)
		Feeling stronger in myself	"I've been more like stronger in myself to like if something needs doing I'm going to do it rather than sitting back and thinking- Oh I can't do that you know?" (Sade) I'm stronger than I was. Mentally, physically, emotionally. (Beverley).
		Increased self-confidence	"I'm more confident, I'm more alive." (Beverley) "I think the growth would be that I'm secure in who I am and not what others may perceive of me" (Brianna) "just coming into your power more as a human being and as a woman, feeling quite strong, that has definitely been something that I've been experiencing I'd say, just from turning it around, you know?" (Amaka)

Appendix L: End of Study summary

Title: Exploring UK Black women's experiences and perceptions of the menopause transition: A Reflexive Thematic Analysis

Background: The menopause transition (MT) is a biopsychosocial process with the potential to affect women's physiological and psychological wellbeing. As such, the need for healthcare to support women's psychological, social and physical health during this life stage has been recognised. Research suggests that women from different ethnic backgrounds may have different experiences. However, there is little contemporary data on UK Black women's experiences. The predominantly White British samples in existing UK research may not fully represent UK Black women's experiences. This knowledge gap may hinder the development of culturally informed interventions.

Aims: This qualitative study aimed to explore UK Black women's experiences of their menopause transition, their perspectives on the role of ethnicity in their experiences and what they found helpful or unhelpful for navigating this life stage.

Method: Semi-structured interviews were conducted with ten women who were 2-6 years postmenopause. Data were analysed using Reflexive Thematic Analysis to construct patterns of meaning across the dataset. Inductive coding was employed to label and capture the meaning of analytically relevant data. Codes were then clustered into themes to reflect significant patterns of meaning which addressed the research aims.

Analysis: Seven themes were developed: starting a journey with an incomplete map, a varied experience, reaching a landmark of ageing, adjusting and carrying on, seeking information and support, picking a path: HRT or going 'natural', and a time of growth.
Most women reported having little prior knowledge of menopause, which some found unhelpful in understanding their experiences. There was variation in the somatic changes experienced and women's responses. Most women used behavioural and cognitive strategies to adjust to these changes. Menopause was perceived as a natural life stage interlinked with Western sociocultural narratives of ageing with the potential for personal growth. Seeking information and support was perceived as helpful. Perspectives on the role of ethnicity varied, with some women not feeling this was relevant, whilst a small number felt that being racially stereotyped had the potential to affect the support and understanding they received from employers or health services.

Suggested implications

- There appears to be a need for accessible, holistic and reliable information on the MT for UK Black women. Based on the women's accounts, a psychological perspective to menopause information could be beneficial for some members of this population.
- The development of community-based menopause psychoeducational groups is a potential avenue for meeting these women's needs.
- Culturally competent care should recognise the range of psychosocial factors that can influence Black women's experiences and perceptions of menopause. Healthcare professionals should be sensitive to the possibility that existing health inequalities and the potential of racial stereotyping may influence some women's perceptions of available support.

Suggested future research

- To conduct research into UK Black women's experiences of menopause psychoeducational groups, their efficacy and beneficial components
- To conduct further research on UK Black women's development and perceived self-growth in midlife through an intersectional lens.

Appendix M Author guidelines notes for chosen journal

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